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OCHAMPUS MANUAL 6010.47-M

CHANGES 1 THROUGH 39 HAVE BEEN INCORPORATED

CHAMPUS POLICY MANUAL

VOLUME TWO
(Program Policy)

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DEPARTMENT OF DEFENSE
UNITED STATES OF AMERICA

CHAMPUS

OFFICE OF THE CIVILIAN HEALTH AND MEDICAL
PROGRAM OF THE UNIFORMED SERVICES

AURORA, CO 80045

October 1982

D1.6/2:

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CHAMPUS POLICY MANUAL

VOLUME TWO - PROGRAM POLICY

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CHAPTER 1

ELIGIBILITY

READEX FICHE best copy available

CHAMPUS POLICY MANUAL

VOLUME TWO - PROGRAM POLICY

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Subject: FORMER SPOUSES	Chapter: 1 Section: 1
Authority: DoD 6010.8-R, Chapter 3, Section B.2.b.	Page: 1.1.1
Approval: Deputy Director	Date: April 19, 1983

ISSUE

When are former spouses of members and former members of the Uniformed Services eligible for CHAMPUS benefits?

BACKGROUND

On September 8, 1982, Public Law 97-252 was signed into effect. Sections 1004 and 1006 of that law provide for continuation of CHAMPUS eligibility for former spouses under certain circumstances. As a result, a spouse of a member or former member of the Uniformed Services may no longer lose CHAMPUS eligibility as of 12:01 a.m. of the day following the date of a final decree of divorce, dissolution, or annulment of the marriage.

* Section 645 of Public Law 98-525, which was effective October 1, *
* 1984, increased the number of individuals who may be eligible as *
* former spouses. *

POLICY

A former husband or wife of a member or former member is eligible
* for CHAMPUS if the former spouse meets conditions 1. through 4. *
* below. *
* 1. The former spouse must be unremarried; *
* 2. The former spouse must not be covered by an employer- *
* sponsored health plan; *
* 3. The former spouse must have been married to a member or *
* former member who performed at least twenty (20) years of service *
* which can be credited in determining the member's or former member's *
* eligibility for retired or retainer pay; and *
* 4. The former spouse must meet the requirements of either A. or *
* B. below. *
* A. The former spouse must have been married to the same *
* member or former member for at least 20 years, at least 20 of which *
* were creditable in determining the member's or former member's *
* eligibility for retired or retainer pay. *
* (1) If the date of the final decree of divorce, *
* dissolution, or annulment was on or after February 1, 1983, the *
* former spouse is eligible for health care furnished on or after *
* February 1, 1983. *

-Continued-

* (2) If the date of the final decree of divorce, *
* dissolution, or annulment is before February 1, 1983, the former *
* spouse is eligible only for health care furnished on or after *
* January 1, 1985. *
* B. The former spouse must have been married to the same *
* member or former member for at least 20 years, at least 15, but *
* less than 20, of which were creditable in determining the member's *
* or former member's eligibility for retired or retainer pay. *
* (1) If the date of the final decree of divorce, *
* dissolution, or annulment is before April 1, 1985, the former spouse *
* is eligible only for care received on or after January 1, 1985. *
* (2) If the date of the final decree of divorce, *
* dissolution, or annulment is on or after April 1, 1985, the former *
* spouse is eligible only during the two-year period beginning on the *
* date of such final decree. *

The law defines former spouses as dependents of the member or former member. Therefore, for purposes of CHAMPUS claims forms submitted by eligible former spouses, block # 7, "Sponsor", shall represent the member or former member.

EXCEPTIONS

Former spouses are eligible for benefits under the Basic Program only. In accordance with 10 USC 1079(d), they are not eligible for any benefits under the Program for the Handicapped.

* A former spouse cannot be a dependent of a NATO member. *

* These former spouse provisions do not apply to CHAMPVA. *

* In order to be eligible, a former spouse must have been married *
* for at least twenty (20) years to one individual. A former spouse *
* who was married to two individuals for ten years to each is not *
* eligible for CHAMPUS, even if all other conditions are met. *

* (Procedural guidelines contained in the COM-FI, Part Two, Chapter 1, *
* Section IV.C.2.a.(4), page 1-30; Section IV.C.3.a.(1)(d), page 1-31; *
Section IV.C.4.b., page 1-34; Section V.C.1.g., page 1-63; and
* Section VI.H.6., page 1-94.1.) *

Subject: MEDICARE ELIGIBILITY FOR CHAMPUS BENEFICIARIES WHO ARE FEDERAL EMPLOYEES	Chapter: 1 Section: 2
Authority: DoD 6010.8-R, Chapter III, E.3.f	Page: 2.1.1
Approval:	Date: APR 19 1983

ISSUE

The effect of Medicare eligibility on certain CHAMPUS beneficiaries who are Federal employees.

BACKGROUND

On January 1, 1983, Federal employees began paying into the Medicare trust fund. Certain CHAMPUS beneficiaries who are Federal employees and over age 65 were not eligible to enroll in Medicare when they became 65. For example, a Federal employee who became entitled to CHAMPUS at age 60, based on retirement from the Reserves, might not have acquired sufficient quarters of coverage from employment under social security to qualify for Medicare at age 65. As of January 1, 1983, these beneficiaries became eligible for Medicare, Part A because of their payment into the trust fund. These beneficiaries may begin enrolling in Medicare in January, 1983, and the earliest their benefits will start is July 1, 1983.

POLICY

CHAMPUS eligibility will end on July 1, 1983, for any CHAMPUS beneficiary who:

Is a Federal employee;

Is age 65 or older or otherwise meets Medicare requirements for eligibility.

Was not eligible for Medicare prior to January 1, 1983.

CHAMPUS eligibility will end whether or not the beneficiary enrolls in Medicare.

Revision No: Revision Date:

Subject: CHAMPUS AND MEDICARE ELIGIBILITY AND END STAGE RENAL DISEASE	Chapter: 1 Section: 2
Authority: DoD 6010.8-R, Chapter 3, E.3.f. and Chapter IV, E.5.g.(2) and Pub. L. 95-292	Page: 2.2.1
Approval: Deputy Director	Date: June 4, 1984

ISSUE

To bring the CHAMPUS Regulation, DoD 6010.8-R, into consonance with the Medicare regulations regarding eligibility and the Medicare end stage renal disease program.

BACKGROUND

Medicare regulations state that an individual becomes eligible for
* Medicare on the first day of the month in which he/she attains age *
* 65. Under previous CHAMPUS regulations, all CHAMPUS beneficiaries, *
except dependents of active duty members, lost their eligibility on their 65th birthday.

In addition, the CHAMPUS Regulation has been amended to correspond with Medicare provisions regarding the end stage renal disease program and donor costs when the beneficiary is Medicare eligible and the donor is a CHAMPUS beneficiary.

POLICY

Attainment of Entitlement to Hospital Insurance Benefits (Part A) under Medicare.

Retirees and all other CHAMPUS eligible persons except dependents of active duty members lose their eligibility for CHAMPUS if they become entitled to Hospital Insurance Benefits (Part A) of Medicare. This is true even though the persons attaining such status live outside the United States where Medicare benefits are not available.

Loss of CHAMPUS Eligibility Due to Age Limitation.

All CHAMPUS beneficiaries, except dependents of active duty mem-
* bers, and beneficiaries not eligible for Part A of Medicare, auto- *
* matically lose CHAMPUS eligibility on the first day of the month in *
* which they attain age 65 on the assumption that they have become *
* eligible for Medicare. For Medicare purposes, a person attains age *

-Continued-

* 65 on the day before his/her birthday. For example, if an individual's birthday is July 1, he/she attains age 65 on June 30 and Part A Medicare eligibility begins June 1. If the person is not entitled * to Part A of Medicare, he or she must file a Social Security Administration "Notice of Disallowance" certifying to that fact with the Uniformed Service responsible for the issuance of his or her identification card so a new card showing CHAMPUS eligibility can be issued.

Loss of CHAMPUS Eligibility Due to End Stage Renal Disease.

Medicare coverage begins with the third (3rd) month after the month a course of maintenance dialysis begins, or with the month in which a patient enters the hospital to prepare to receive a transplant (providing the transplant is performed within the following two * months. If the transplant is not performed until more than 2 months after the preparatory hospitalization, Medicare will begin with the second month prior to the month of transplant.) All beneficiaries, * except dependents of active duty members, lose their CHAMPUS eligibility when Medicare coverage becomes available to a person because of end stage renal disease.

Example. If a course of dialysis began on January 1, Medicare coverage would be effective on April 1. If the course of maintenance dialysis began on January 31, Medicare coverage would still be effective April 1. Medicare waives the 3-month waiting period if the patient participates in a self-care training program (in expectation of entering self-dialysis) prior to the third month after the month a regular course of dialysis is initiated.

Reinstatement of CHAMPUS Eligibility.

Age limitation. Beneficiaries who lose their CHAMPUS eligibility because they reached the age limitation and were eligible for Part A, cannot be reinstated under CHAMPUS. Beneficiaries who retain CHAMPUS eligibility after the specified age limitation because they were not eligible for Medicare Part A but who become eligible for Medicare because of end stage renal disease, may be reinstated under CHAMPUS upon loss of Medicare because of successful treatment of the end stage renal disease.

End Stage Renal Disease. Medicare eligibility ceases for chronic * renal disease patients with the thirty-sixth (36th) month after the month in which a successful kidney transplant takes place or with *

-Continued-

* the twelfth (12th) month after the month in which the course of *
maintenance dialysis ends. At this point CHAMPUS eligibility resumes if the person is otherwise still eligible. He or she is required to take action to be reinstated as a CHAMPUS beneficiary and to obtain a new CHAMPUS identification card.

Note: If a transplant should fail later than thirty-six (36) months after surgery, Medicare eligibility will immediately be
* reestablished if the individual files an application, still meets *
* the insured status requirement, and begins a regular course of *
* dialysis or undergoes another transplant. If an individual begins a *
* regular course of dialysis more than 12 months after the previous *
* course ended, Medicare entitlement is immediately reestablished if *
* the individual files an application and still meets the isured *
* status requirements.

Donor Costs When the Patient is a Medicare Beneficiary and the Donor is a CHAMPUS Beneficiary.

In most instances, for costs related to kidney transplants, Medicare (not CHAMPUS) benefits will be applicable. If a CHAMPUS beneficiary participates as a kidney donor for a Medicare beneficiary, Medicare will pay for expenses in connection with the kidney transplant to include all reasonable preparatory, operation and postoperation recovery expenses associated with the donation (postoperative recovery expenses are limited to the actual period of recovery).

Subject: RESTORATION OF CHAMPVA ELIGIBLIITY FOR CERTAIN MEDICARE BENEFICIARIES	Chapter: 1 Section: 3
Authority: Section 5, Public Law 97-251	Page: 3.1.1
Approval:	Date: APR 19 1983

ISSUE

CHAMPVA beneficiaries lose their eligibility when they become entitled to hospital insurance benefits under Part A, Hospital Insurance, of title XVIII of the Social Security Act. When can these beneficiaries have their CHAMPVA eligibility restored?

BACKGROUND

On September 8, 1982, Public Law 97-251, the Veterans' Administration Health-Care Programs Improvement and Extension Act of 1982, was signed into effect. Section 5 of that law provides for restoration of CHAMPVA eligibility in certain circumstances for certain beneficiaries who previously lost their eligibility when they became entitled to Part A of Medicare. As a result, certain beneficiaries may have CHAMPVA eligibility in addition to their entitlement to Medicare, Part A.

POLICY

A spouse, surviving spouse, or child who was previously eligible for CHAMPVA but who lost his or her eligibility upon becoming entitled to Medicare Part A (42 U.S.C. 1395c et seq.) may have CHAMPVA eligibility restored when they have exhausted any part of their Medicare Hospital Insurance benefits. This can include exhaustion of their benefits for a particular year or their lifetime reserve benefits. Once CHAMPVA eligibility is restored under this provision, it shall be continued regardless of subsequent renewed eligibility for Medicare Part A benefits. In all cases, however, CHAMPVA shall be secondary payer to Medicare, and all claims must be processed first by Medicare according to normal double coverage procedures.

The Veterans Administration is responsible for determining eligibility under this provision, and FI's need only process the claims according to the eligibility determinations made by the VA.

EFFECTIVE DATE

October 1, 1982.

Revision No: Revision Date:

Subject: REALTIME AUTOMATED PERSONNEL IDENTIFICATION SYSTEM (RAPIDS)	Chapter: 1 Section: 4
Authority: DoD 6010.8-R, Chapter III, H.	Page: 4.1.1
Approval: Keith W Curtis	Date: MAY [illegible]

ISSUE

New Uniformed Services identification cards to be tested at five sites.

BACKGROUND

Ineligible persons are obtaining medical care in the military health care system. In response to earlier Congressional interest in the problem, the Defense Enrollment Eligibility Reporting System (DEERS) was implemented as an initial step in eliminating this kind of fraud, waste and abuse in the uniformed services benefits system. The second step is a system called the Realtime Automated Personnel Identification System (RAPIDS). The new test ID card is part of this system.

The interface between these two systems will permit Service personnel offices to verify an applicant's eligibility for an ID card by documentation and/or the DEERS data base, produce an ID card and simultaneously update the data base as required.

POLICY

Five test sites have been selected for the evaluation of a new ID card system for the Uniformed Services. Four different cards will be used in the test. Facsimiles of the card are at enclosure 1. Concerned fiscal intermediaries will inform providers in the test areas of this identification card test and will provide facsimiles of the cards to all affected providers.

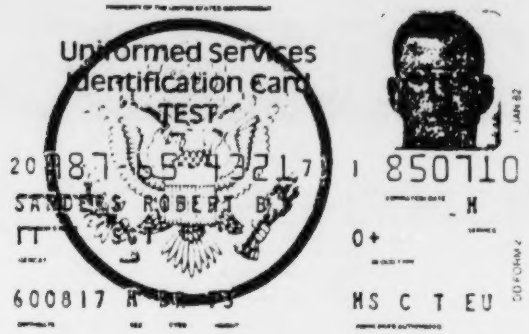
POLICY CONSIDERATIONS

Valid test ID cards will be given to Uniformed Services personnel at the following test sites only:

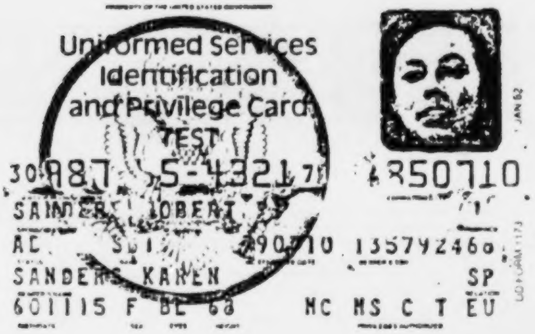
-Continued-

	START DATE
Marine Corps Air Station, CHERRY POINT, Cherry Point, NC	04 Apr 83
SEYMOUR-JOHNSON AFB, Goldsboro, NC	04 Apr 83
LITTLE CREEK AMPHIBIOUS BASE, Little Creek, Va.	18 Apr 83
FT LEE, Ft. Lee, Va.	25 Apr 83
Military Entrance Processing Station, RICHMOND, Richmond, Va.	02 May 83

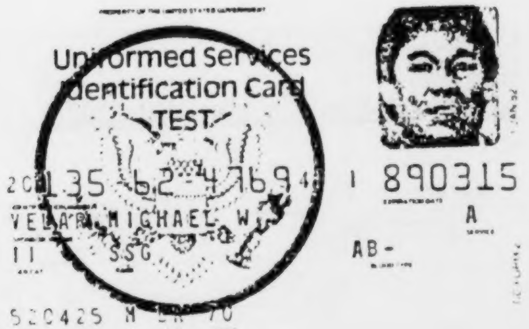
The FI's should advise the providers that the letters MC appearing above the statement "PRIVILEGES AUTHORIZED" in the lower right hand corner of the test ID card will indicate if the person is eligible for CHAMPUS benefits.



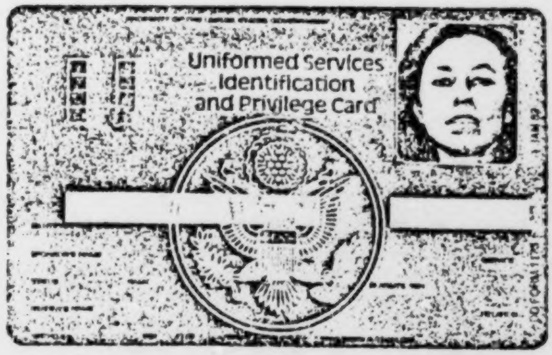
Uniformed Services
Identification Card
TEST
20 987-65-4321 7 1 850710
SANDERS ROBERT B M
IT SGT O+
600817 M BR 73 MS C T EU
1 JAN 82
DD FORM 2



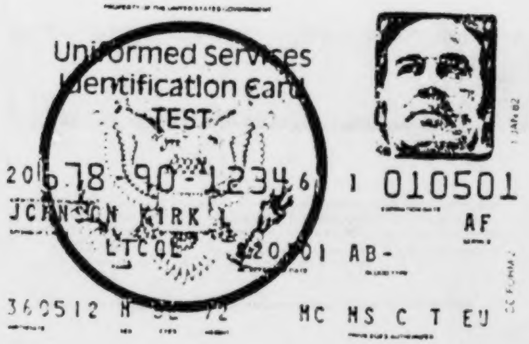
Uniformed Services
Identification
and Privilege Card
TEST
30 987-65-4321 7 850710
SANDERS ROBERT B
AC SGT 890710 135792468
SANDERS KAREN SP
601115 F BL 68 MC MS C T EU
1 JAN 82
DD FORM 1173



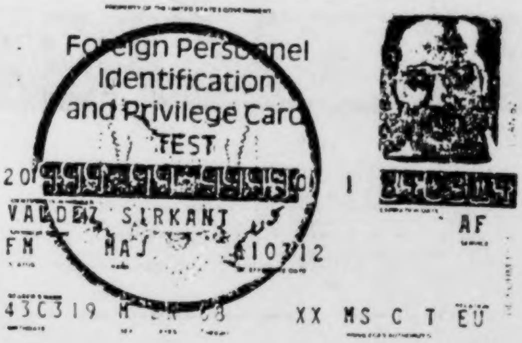
Uniformed Services
Identification Card
TEST
20 135-62-4769 4 1 890315
VELAR MICHAEL W A
II SSG AB-
520425 M BR 70



Uniformed Services
Identification
and Privilege Card
1 JAN 82
DD FORM 1173



Uniformed Services
Identification Card
TEST
20 678-90-1234 6 1 010501
JOHNSON KIRK L AF
LTCOL 820501 AB-
360512 M BL 72 MC MS C T EU
1 JAN 82



Foreign Personnel
Identification
and Privilege Card
TEST
20 [redacted] 0 1 [redacted]
VALDEZ SIRKANT AF
FM MAJ 810712
430319 M BR 68 XX MS C T EU

[redacted]

WARNING: Use of this authorization by other than person named thereon, or any use in violation of provisions of Dependents' Medical Care Act of 1956 renders user liable for prosecution under applicable federal laws pertaining to false statements. (18 USC 1001)

Postmaster, return to: Department of the Navy
NMPC 08, Washington, D.C. 20370
If found—
Drop in any mail box

Identification for purposes of the Geneva Convention relative
to treatment of prisoners of war of August 12, 1949
Geneva Convention Identification Card

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Subject: ELIGIBILITY OF NATO DEPENDENTS FOR PFTH	Chapter: 1 Section: 5
Authority: DoD 6010.8-R, Chapter V, Section A.4.	Page: 5.1.1
Approval: Keith W Curtis	Date: 19 JUL 1983

ISSUE

Are NATO dependents eligible for benefits under the CHAMPUS Program for the Handicapped?

BACKGROUND

There have been a number of inquiries recently concerning the eligibility of NATO dependents for benefits under the CHAMPUS Program for the Handicapped. Eligibility under the Program for the Handicapped is limited to dependents of active duty sponsors. "Active duty" is defined by Regulation as "full-time duty in the Uniformed Service of the United States." This, in effect, excludes military members of the armed forces of foreign nations. The language of DoD 6010.8-R is in agreement with the Congressional intent in establishing the PFTH which was to help those dependents excluded from state resources because of residency requirements.

POLICY

NATO dependents are not eligible for benefits under the CHAMPUS Program for the Handicapped.

Revision:	Revision Date:

Subject: CUSTODIAL PROVISIONS AND ENTITLEMENT TO MEDICARE	Chapter: 1
	Section: 6
Authority: DoD 6010.8-R, Chapter IV. E.12.e.	Page: 6.1.1
Approval: Deputy Director	Date: FEB 14 1984

ISSUE

The effect of Medicare eligibility on CHAMPUS beneficiaries who qualify for the custodial care exception.

BACKGROUND

When the CHAMPUS Regulation, DoD 6010.8-R, was implemented on June 1, 1977, a more specific definition of custodial care became effective. As a result of comments at public rule-making hearings and specific case reviews, an amendment to the regulation on custodial care was published. This amendment allowed for continued benefits in those cases where reasonable care had been authorized or reimbursed under the CHAMPUS Basic Program prior to June 1, 1977, even though under DoD 6010.8-R such care would be excluded.

In amending the custodial care provision one issue was not resolved --the effect of Medicare eligibility. The policy on custodial care benefits is herein further clarified.

POLICY

A beneficiary who qualifies for the custodial care exception set forth in DoD Regulation 6010.8-R and attains the age of sixty-five (65) will continue to receive CHAMPUS benefits for custodial care services, supplies, and prescription drugs only, even if the beneficiary is entitled to Medicare Hospital Insurance (Part A).

Eligibility for all other CHAMPUS benefits will cease whether or not a service or supply is covered by Medicare.

EFFECTIVE DATE

June 1, 1977

Subject: SERVICE-CONNECTED DISABILITIES	Chapter: 1 Section: 7
Authority: DoD Appropriation Act, 1980	Page: 7.1.1
Approval: Keith W Curtis Deputy Director	Date: February 14, 1984

POLICY

Services and supplies provided to CHAMPUS beneficiaries who are Veterans with a service-connected disability are covered.

EXCEPTIONS

CHAMPUS benefits may not be extended for any care received from civilian providers for which the Veterans Administration has made payment or reimbursement or has authorized such payment or reimbursement to be made.

EFECTIVE DATE

October 1, 1979

Revision: Revision Date:

CHAPTER 2

PROVIDERS

CHAPTER 2 - PROVIDER POLICY

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Subject: EMPLOYER-OPERATED MEDICAL FACILITIES	Chapter: 2 Section: 1
Authority: DoD 6010.8-R, Chapter IV.G.11&12	Page: 1.1.1
Approval: Deputy Director	Date: January 23, 1984

ISSUE

Whether CHAMPUS benefits may be extended for care provided by employer-operated medical facilities.

BACKGROUND

Medical facilities operated by employers, labor unions or other organizations for the benefit of their employees ordinarily do not impose charges for their services.

POLICY

CHAMPUS provides benefits on the basis of incurred expenses; that is, the beneficiary must actually be billed for a service and have a legal obligation to pay the bill. When no charge is incurred by the patient, CHAMPUS will not cost-share or apply any amounts to satisfy a deductible or cost-shares.

POLICY CONSIDERATIONS

A "dummy" bill made up by an employer-operated medical facility only for the expressed purpose of submission to CHAMPUS does not represent incurred charges because the facility does not actually expect payment of the charges and is not a legal obligation to pay.

Under some circumstances, an employer-operated medical facility may charge a percentage of the actual cost of services provided. Benefits may be extended for that percentage of the covered medical care the patient is actually obligated to pay if similiar charges would be made to other patients in the absence of CHAMPUS. Double coverage guidelines would apply. (See Volume 2, Chapter 3, Section 2 of this Policy Manual)

Subject: ALTERNATE BIRTHING CENTERS	Chapter: 2 Section: 1
Authority: DoD 6010.8-R, Chapter IV. B.3.	Page: 1.2.1
Approval: Deputy Director	Date: FEB 14 1984

BACKGROUND

The alternate birthing center is a new concept for expectant parents who anticipate a normal, uncomplicated birth. The emphasis is on the provision of maternity and newborn care in a warm, homelike atmosphere. There are both freestanding and hospital-based birthing centers.

POLICY

Services provided by a birthing center that is part of an approved hospital are covered and processed on an inpatient cost-sharing basis.

Services provided in freestanding birthing centers are not covered.

POLICY CONSIDERATIONS

Services provided by health professionals and physicians who are employed by or under contract with a freestanding birthing center are not covered. If an authorized individual professional provider who is not employed by or under contract with the freestanding birthing center attends a patient who delivers in the freestanding birthing center, the services of that individual professional provider may be covered.

Revision: Revision Date:

Subject: EATING DISORDER PROGRAMS	Chapter: 2 Section: 1
Authority: DoD 6010.8-R, Chapter VI, G3; G28; G43. DoD 6010.8-R, Chapter VI, B; C.	Page: 1.3.1
Approval: Deputy Director	Date: 19 July 1983

DESCRIPTION

An eating disorder program is an institutionally based regimen for the treatment of those mental disorders which are characterized by gross disturbances in eating behavior.

POLICY

A freestanding eating disorder program is not eligible for status as an authorized institutional provider of services and supplies to the CHAMPUS.

POLICY CONSIDERATIONS

1. The use of the term "eating disorder program" by an institutional provider of mental health services is not sufficient in itself to establish CHAMPUS institutional provider status.

2. Claims for services and supplies (otherwise authorized by the CHAMPUS) which are provided within an eating disorder program operated by a CHAMPUS authorized institutional provider **may not** be denied solely on the basis that the services were provided in an eating disorder program.

3. Services provided by a health professional employed by or under contract with a freestanding eating disorder program are excluded from the CHAMPUS.

4. Services (otherwise authorized by the CHAMPUS) provided by a CHAMPUS authorized individual professional provider who is **not** employed by or under contract with the freestanding eating disorder program providing inpatient or outpatient services to a beneficiary **are not** excluded from the CHAMPUS.

NOTE: This guidance is a clarification of guidance on eating disorder programs issued on July 19, 1983. Specific guidance
* on eating disorders is at Vol.I, Chap.8, Sec.13, Pg. 13.1.1. *

Subject: PHYSICIAN REFERRAL AND SUPERVISION	Chapter: 2 Section: 2
Authority: DoD 6010.8-R, Chapter VI, A.6.	Page: 2.1.1
Approval: Deputy Director	Date: December 19, 1985

ISSUE

In order to be considered for benefits on a fee-for-service basis, the services of the following individual professional providers of care may be provided only if the beneficiary/patient is referred by a physician for the treatment of a medically-diagnosed condition. A physician must also provide continuing and ongoing oversight and supervision of the program or episode of treatment provided by these individual providers:

a. Licensed Registered Nurses.

b. Nurse Anesthetists.

c. Licensed Practical or Vocational Nurse.

d. Audiologist.

e. Speech Therapists (Speech Pathologists).

f. Licensed Registered Physical Therapists.

g. Marriage, Family or Pastoral Counselors.

POLICY

a. A physician must establish a diagnosis which, in order to be considered for benefits, must describe a CHAMPUS-covered condition. This means the physician must actually see the patient, do an evaluation and arrive at an initial diagnostic impression prior to referring the patient. Any change in the referral diagnosis must be coordinated with the referring physician.

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b. The referral of the patient by a physician is a quality assurance matter. The overall management of the patient rests with the physician and, in order to assure appropriate case management, coordination must be made with the referring physician on an on-going basis. Any services provided prior to examination and subsequent referral by a physician are not payable.

c. Physician supervision means the physician provides overall medical management of the case. The referring physician does not have to be physically located on the premises of the provider to whom the referral is made. Communication back to the referring physician is an indication of medical management.

d. Military physicians may refer patients to civilian providers. Because of the mobility of military physicians due to transfers, retirements and discharges, if the original referring physician has relocated, another military physician may assume responsibility for the case upon review of the military treatment facility clinical record, a narrative of the patient's present status and the proposed treatment plan.

Subject: NURSE ANESTHETISTS	Chapter: 2 Section: 2
Authority: DoD 6010.8-R, Chapter VI.C.3.c. *	Page: 2.4.1 *
Approval: Deputy Director	Date: January 23, 1984

ISSUE

Benefits for anesthesia services rendered by a nurse anesthetist

POLICY

Anesthesia services rendered by a nurse anesthetist are covered when the following criteria are met:

1. There is a physician referral and the anesthesia services are performed under the supervision of a physician or dentist;
2. The nurse anesthetist is operating within the scope of his or her license or certification required in the jurisdiction where practicing; and
3. The nurse is a licensed registered nurse.

POLICY CONSIDERATIONS

A fee-for-service billing is acceptable when the nurse anesthetist is an independent individual professional provider.

If the nurse anesthetist is an employee of an institution or physician, the anesthesia services must be billed as part of the physician's or institution's charges.

Subject: CERTIFIED CLINICAL SOCIAL WORKER	Chapter: 2 Section: 2
Authority: Defense Appropriation Act, Fiscal Year 1983 *	Page: 2.5.1 *
Approval: Deputy Director	Date: March 1, 1984

ISSUE

Certified Clinical Social Workers.

BACKGROUND

The Defense Appropriation Act, Fiscal Year 1981 directed CHAMPUS to conduct a test reimbursement program for covered services provided by clinical social workers independent of physician referral or supervision. The test period was extended through September 30, 1982, by the Defense Appropriation Act, Fiscal Year 1982. This test reimbursement program was effective for claims received and processed from December 15, 1980, through September 30, 1982, and continued from October 1 through December 20, 1982, based upon provisions of the Continuing Resolution.

The Senate Report on the Department of Defense Appropriations Bill for the fiscal year ending September 30, 1983, stated in part, that "Based on the successful pilot program, the Committee has included bill language to permit direct reimbursment of clinical social workers who provide mental health services. ...No quality of care problems have arisen, and reimbursement of clinical social workers costs less than the traditional physician gate-keeper approach." Thus, the Defense Appropriation Act, Fiscal Year 1983, included certified clinical social workers as authorized individual providers of care and terminated the test reimbursement program.

POLICY

A certified clinical social worker may provide covered services independent of physician referral and supervision when the clinical social worker meets the standards established by the Regulation (Chapter VI, subparagraph C.3.c.(6)) for CHAMPUS-authorized clinical social workers and is practicing within the scope of his or her license. The clinical social worker must meet the following criteria:

1. Is licensed or certified as a clinical social worker by the jurisdiction where practicing; or, if the jurisdiction does not provide for licensure or certification of clinical social

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workers, is certified by a national professional organization offering certification of clinical social workers; and

2. Has at least a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education; and

3. Has had a minimum of two years or three thousand hours of post-master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate clinical setting, as determinded by the Director, OCHAMPUS, or a designee.

Medical services must be rendered by or under a physician's supervision. Lack of physician involvement when required by the circumstances of the case is a basis for denial of payment on quality grounds.

Claims for mental health services provided by clinical social workers are subject to the limitations on psychiatric procedures as specified in the Regulation and to the established peer review requirements.

EFFECTIVE DATE

December 21, 1982

Subject: CERTIFIED PSYCHIATRIC NURSE SPECIALIST	Chapter: 2 Section: 2
Authority: DoD 6010.8-R, Chapter VI, C.3.c.(7) *	Page: 2.6.1 *
Approval: Deputy Director	Date: December 5, 1984

ISSUE

Certified Psychiatric Nurse Specialist

POLICY

1. A certified psychiatric nurse specialist may provide covered care independent of physician referral and supervision. For purposes of CHAMPUS, a certified psychiatric nurse specialist is an individual who:

a. Is a licensed, registered nurse; and

b. Has at least a master's degree in nursing with a specialization in psychiatric and mental health nursing; and

c. Has had at least two years of post-master's degree practice in the field of psychiatric and mental health nursing, including an average of eight hours of direct patient contact per week; or

d. Is listed in a CHAMPUS-recognized, professionally sanctioned listing of clinical specialists in psychiatric and mental health nursing.

2. Claims for mental health services provided by a certified psychiatric nurse specialist are subject to the limitations on psychiatric procedures as specified in the Regulation and to the criteria in the "Utilization Review of Mental Health Services," Volume II, Appendix A, Policy Manual.

EFFECTIVE DATE

November 13, 1984

Revision No: 1 Revision Date: December 19, 1985

Subject: CLINICAL PSYCHOLOGIST
Chapter: 2
Section: 2
Authority: DoD 6010.8-R, Chapter VI, C.3.c.(1) *
Page: 2.7.1 *
Approval: Deputy Director
Date: December 5, 1984

ISSUE

Clinical Psychologist

POLICY

1. Clinical psychologist. For purposes of CHAMPUS, a clinical psychologist is an individual who:

a. Is licensed or certified by the state for the independent practice of psychology; and

b. Possesses a doctoral degree in psychology from a regionally accredited university; and

c. Has had two years of supervised clinical experience in psychological health services of which at least one year is post-doctoral and one year (may be the post-doctoral year) is in an organized psychological health service training program; or

d. Is listed in the National Register of Health Service Providers in Psychology, published by the Council for the National Register of Health Service Providers in Psychology.

2. Claims for mental health services provided by a clinical psychologist are subject to the limitations on mental health disorders as specified in the Regulation and to the criteria in the "Utilization Review of Mental Health Services," Volume II, Appendix A, Policy Manual.

EFFECTIVE DATE

November 13, 1984

POLICY CONSIDERATIONS

The doctoral degree no longer needs to specify "clinical psychology;" however, the degree must be clearly identified as a professional

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psychology program, i.e., Ph.D. in psychology or a Psy.D. Any other designation is not considered to meet the Regulation criteria. FIs should check their records to ensure that only authorized psychologists are contained in the provider file. Providers who do not meet this requirement are to be offered the alternative of applying under the program as a marriage, family and pastoral counselor or other appropriate category or of applying for listing in the National Register (see 1d, above).

Subject: MARRIAGE, FAMILY OR PASTORAL COUNSELORS	Chapter: 2 Section: 2
Authority: DoD 6010.8-R, Chapter VI, C.3.d.(1) *	Page: 2.8.1 *
Approval: Deputy Director	Date: December 5, 1984

ISSUE

Marriage, Family or Pastoral Counselors

POLICY

1. Provider Criteria. A marriage, family or pastoral counselor must meet the requirements outlined in Chapter VI, C.3.d.(1) of the CHAMPUS Regulation (DoD 6010.8-R).

2. Medical Necessity. Services must be medically necessary for treatment of a covered medical condition. Marriage and family counseling, as such, is not a benefit under CHAMPUS. Only psychotherapy which is medically required to treat a diagnosed mental condition is payable.

3. Physician Referral and Supervision.

a. According to Chapter 55, title 10, United States Code, Section 1079(a)(8), "services of pastoral counselors, family and child counselors, or marital counselors may not be provided unless the patient has been referred to the counselor by a medical doctor for treatment of a specific problem with the results of that treatment to be communicated back to the medical doctor who made the referral."

b. A physician must establish a diagnosis which, in order to be considered for benefits, must describe a CHAMPUS-covered condition. There must be presenting symptoms, and there must be distress and functional impairment. The physician must refer the patient to the marriage and family counselor for such psychotherapeutic services as are required to treat the condition.

c. The referral of the patient by a physician is a quality assurance matter. The overall management of the patient rests with the physician and, in order to assure appropriate case management, the counselor must coordinate with the referring physician. The referring physician must actually see the patient, do an evaluation and arrive at an initial diagnostic impression prior to referring the the patient to a marriage, family or pastoral counselor. A

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physician's examination is necessary so the patient's condition can be
*evaluated to determine whether treatment by a marriage, family or *
pastoral counselor would be appropriate. Any psychotherapeutic
services provided by a marriage, family or pastoral counselor prior to
*examination and subsequent referral by a physician are not payable. *

d. The referring physician does not have to be physically located on the premises where the counselor is providing services; however, the counselor must certify on each claim that a written communication has been made or will be made to the referring physician of the results of the treatment. Such communications should be made at the end of the treatment or more frequently if required by the referring physician.
*Also, any change in the referring diagnosis recommended by the *
*counselor must be coordinated with the referring physician. *

* 4. Claims Documentation. *
* *
* a. With the first claim for an episode of care from a marriage *
*family or pastoral counselor, documentation is required of the *
*physician's examination, evaluation and referral. This should *
*consist of a copy of that section of the patient's clinical record *
*where the physician performed an examination and made a provisional *
*diagnosis. There must be a provisional referring diagnosis (valid *
*DSM-III diagnosis). If the referral is from a military physician, a *
*copy of the physician's evaluation is required, in addition to a *
*completed cooperative care form (Standard Form 513 or DD Form 2161). *
*The name and address of the referring physician is required. *

* b. At the points of review established in the Mental Health *
*Treatment Utilization Review System, the marriage, family or *
*pastoral counselor must submit a statement from the referring *
*physician as to the need for continuing care as part of the treatment *
*plan. In lieu of a separate statement, the physician may countersign *
*the treatment plan. Such documentation is an indication of the medical *
*cal necessity of continuing the treatment plan and medical management *
*of the case. *
* NOTE: Development of claims from marriage, family or pastoral *
*counselors **for care which is already underway when this policy is** *
***implemented** shall be delayed until the case is scheduled for a routine *
*tine review (unless the FI questions or is monitoring a particular *
*provider and may want to do it sooner). It is not necessary or *
*desirable to automatically suspend claims in those cases where care *
*is already underway. The documentation of physician referral (as *
*described in "a" above), shall be requested when the case reaches a *
*scheduled review point and would otherwise have to be suspended to *
*obtain a treatment report. In this way, the physician referral *
*documentation can be requested at the same time as the treatment *
*report, minimizing delays in claims turnaround time. *

Subject: HEALTH MAINTENANCE ORGANIZATIONS (HMOs)	Chapter: 2 Section: 3
Authority: DoD 6010.8-R, Chapter VI, E.	Page: 3.1.1
Approval: Deputy Director	Date: December 29, 1982

ISSUE

Will CHAMPUS pay for services rendered to CHAMPUS beneficiaries by professional corporations and associations and hospitals affiliated with HMOs?

BACKGROUND

In the past CHAMPUS has not recognized HMOs as authorized providers for several reasons. First, the CHAMPUS Regulation does not recognize HMOs as authorized providers. Second, HMOs emphasize and frequently provide preventive services which are normally not covered by CHAMPUS. Third, HMOs generally have provided their services only to members and usually at no, or little, cost. Thus, since membership in HMOs is voluntary and the HMO is usually designed to cover essentially all medical needs of its members, there has been no reason for CHAMPUS to recognize HMOs. It would be impractical routinely to provide secondary coverage to HMO members who are required to make only token payments for services, since the administrative cost of processing claims for such services would almost always exceed the amount claimed. Last, until recently HMOs rarely provided services to nonmembers.

This policy affected only HMOs such as the Kaiser Foundation Health Plan which have physicians dedicated exclusively to the HMO. Those HMOs which simply contract with privately practicing physicians or with hospitals to provide services to their members have not encountered problems since these providers are often CHAMPUS-authorized providers in their own right, and render services not only to HMO members but also to CHAMPUS beneficiaries who are not members of the HMO.

POLICY

If the conditions in Sections 1. or 2. below are met, CHAMPUS will provide benefits for covered medically necessary services rendered by an authorized professional or institutional provider affiliated with an HMO. Coverage of services should not be dependent on the billing entity but rather on the provider which renders the services. Nor

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should the fact that the provider is employed by an HMO or a hospital is run by an HMO preclude payment if all other requirements are met. CHAMPUS will provide payment for covered medically necessary services rendered by professional corporations and associations and by hospitals that are affiliated with HMOs.

Provider components of HMOs must meet CHAMPUS provider certification standards. That is, HMO-affiliated hospitals must meet CHAMPUS standards for acute care hospitals, and professional providers employed by or affiliated with HMOs must meet the standards for clinics/group practices.

Reimbursement for services rendered by provider components of HMOs shall follow the same procedures as for services rendered by other providers.

1. Services rendered to nonmembers - All covered medically necessary services rendered to CHAMPUS beneficiaries who are not members of the HMO can be reimbursed by CHAMPUS.

2. Services rendered to members - CHAMPUS will reimburse for services rendered to CHAMPUS beneficiaries who are members of the HMO if all of the following conditions are met:

a. The service is a CHAMPUS benefit.

b. The service is medically necessary.

c. The service is specifically excluded from HMO coverage or the HMO has a specific limitation on how much it will pay for the service. Where the HMO has a limitation on how much it will pay, CHAMPUS will reimburse only for that portion of the charge which the HMO does not cover.

d. The amount billed to CHAMPUS is not a user's fee. A user's fee is an amount, usually nominal, which the beneficiary must pay every time the beneficiary receives services from the HMO. Such user's fees do not vary but are always the same amount regardless of the scope of services provided to the beneficiary. Under no circumstances will CHAMPUS reimburse for such user's fees. User's fees also include those amounts which members are expected to pay for prescriptions regardless of the manner in which the HMO determines these amounts. However, amounts billed to CHAMPUS and which vary depending

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* on the services rendered, such as a requirement that the beneficiary *
* pay a percentage of the charges or that the beneficiary pay all *
* charges over a specified amount, are not considered user's fees, and *
* CHAMPUS will reimburse for these amounts. Nor are deductible amounts *
* considered to be user fees, and they are also reimbursable. *

EFFECTIVE DATE

1. Services rendered to nonmembers - effective for claims processed on or after December 29, 1982.

2. Services rendered to members - effective for claims processed
* on or after June 1, 1983. *

EXCEPTIONS

This Policy Manual issuance does not pertain to the HMO demonstration implementation currently underway in Portland, Houston and Minneapolis.

CHAPTER 3

PAYMENTS

CHAPTER 3 - PAYMENTS POLICY

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Subject: ALLOWABLE CHARGES - GENERAL	Chapter: 3
	Section: 1
Authority: DoD 6010.8-R, Chapter VI, E.3.a.	Page: 1.1.1
Approval: Robert D Seamon for Director	Date: February 3, 1984

ISSUE

What is the CHAMPUS-determined allowable charge?

POLICY

The term "allowable charge" is the maximum amount CHAMPUS will authorize for medical and other health services furnished by physicians, medical groups, professional providers, independent laboratories, suppliers of ambulance services, and suppliers of durable medical equipment, medical supplies and prostheses, etc. In other words, it is the CHAMPUS-determined reasonable charge. To avoid confusion with the different meanings of the term "reasonable charge" as used in CHAMPUS and Medicare, the term "allowable charge" shall be used as the preferred reference to the CHAMPUS-determined reasonable charge in all program documents and correspondence.

* The allowable charge is the lower of the actual billed charge or the *
* prevailing charge (or amount derived from a conversion factor) made *
* for a given procedure in the state. Prevailing charges are to be *
* developed on a statewide, nonspecialty basis and are set at the 80th *
* percentile of charges made for a given procedure during the base *
* period. Nonspecialty basis means that there is to be no distinction *
* between types of physicians, although separate profiles are to be *
* developed for different classes of providers, e.g., physicians and *
* non-physicians. See COM-FI, Part 2, Chapter 4, Section I.B.4.a.(2)(a).*

* The law and regulation require that CHAMPUS profiles be updated at *
* least once per year, and this will occur on October 1 unless otherwise *
* directed by the Director, OCHAMPUS (or a designee). *

* See Part 2, Chapter 4 of the COM-FI for additional specific infor- *
* mation on the determination of CHAMPUS allowable charges. *

Revision No: 1 Revision Date: August 26, 1985

Subject: ALLOWABLE CHARGES - APPLICATION OF CRITERIA	Chapter: 3 Section: 1
Authority: DoD 6010.8-R, Chapter VI, E.3.a.	Page: 1.2.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

ISSUE

How are allowable charge determinations to be made in the determination of CHAMPUS reimbursement?

POLICY

The allowable charge for a covered service shall be the actual charge for the service when that charge is no higher than the applicable prevailing charge.

The fiscal intermediary must exercise judgement in applying the allowable charge criteria so that its allowable charge determinations are realistic. In addition to data on physicians' charges to their patients in general, fiscal intermediaries shall take into account special factors in individual cases that might affect the reasonableness of charges under CHAMPUS. The special factors could involve travel, medical complications, or other unusual circumstances such as prolonged time and attention required by a patient's condition, etc. (as described in Section 4.1.).

1. Separate Allowable Charge Determination for Each Service.

Different services and supplies for which charges are made under CHAMPUS, may not (except in the two situations described below) be grouped together for the purpose of making one overall allowable charge determination. Thus, in processing a claim for reimbursement, a separate allowable charge determination must be made with respect to each separate service or item for which a charge is made. For example, one overall allowable charge determination may not be made for 12 inpatient hospital visits for which a total charge of $127 was made, if that total charge consists of: (1) a $15 fee for the initial inpatient hospital visit; (2) a $12 fee for the second inpatient hospital visit; and (3) a $10 fee for each ten subsequent inpatient hospital visits. Where different prevailing charges are applicable to each of these three types of visits, a separate allowable charge determination must be made for each type of visit. Similarly, if a physician reports an office

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visit, including an examination, urinalysis, and white blood cell count, three allowable charge determinations would be necessary if additional amounts were charged above the usual office fee for the additional services.

Exception 1. An exception to this might occur with respect to the components of a uniform series of tests and examinations, or a common combination of procedures which can be treated as a single procedure, and for which the fiscal intermediary can establish the prevailing charge. Such a "single procedure" would, by definition, have to always consist of the same components, and would have to be generally recognized by physicians and other persons furnishing covered services as a common combination of procedures or uniform series of tests and examinations. In other words, the description of the service as well as the name and procedure code used to identify it would have to be known and recognized as pertaining to a particular, unvarying group of tests, examinations, or procedures. An exception to the "unvarying" requirement is found in multi-channel laboratory tests. (See Section 3.4.)

There may be a wide variety of uniform series of tests and examinations, or common combinations of procedures. Each one would have to be properly identified, and a separate allowable charge would have to be determined for each. For example, one service may be described as "an office visit including a comprehensive diagnostic history and physical examination." Another service may be described as "an office visit with EKG." These two services may not be treated as the same common combination of procedures for the purpose of determining allowable charges or for compiling profile information.

Physicians or other persons who perform uniform series of tests and examinations or common combinations of procedures may itemize the individual components of these services on their bills if they wish, and make separate charges for them. Where this occurs, a separate allowable charge determination for each item is necessary.

Exception 2. Another exception to the requirement that separate allowable charge determinations must be made for each service may occur when a physician bills on the basis of a "global fee" or "package charge" covering a period of treatment, instead of on the basis of his charges for individual services rendered. The fiscal intermediary may determine that such a charge is allowable if it can establish that the

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"package charge" or "global fee" does not exceed the total of the amounts which it would have deemed allowable if the physician had made charges on the basis of an itemized list of services. Such a determination must be based on information the fiscal intermediary has about the prevailing charges in the state, and about the nature of and frequency of the services rendered for which a package charge is made. However, a contact with the physician to obtain such information need not be made by the fiscal intermediary where it can obtain the information from its own files, the patient's prior claims history, etc. Also, the fiscal intermediary may exercise its discretion and judgment based on a general knowledge of the fee charging practices of the physician, its knowledge of the normal manner of treatment applicable to particular diagnoses, etc., to determine what services were rendered, and how frequently they were rendered, etc. In all cases, however, the fiscal intermediary must be able to document what information or judgment was used as the basis for its determination. Where an allowable charge determination is made with respect to a "flat fee" or "package fee," the prevailing charge profile methodology shall be annotated to reflect the determination process. However, the charge must not be included in the fiscal intermediary's calculation of the prevailing charge for a particular procedure unless the global fee has a recognized code and description as noted in Exception 1 above.

2. Low Charge May Not be Used to Offset High Charge.

The fiscal intermediary shall not make a "package charge" or a "flat fee" out of separately itemized charges on a bill for the purpose of offsetting high charges with low charges. Where in the same claim (a) the charge for one service is lower than the highest amount the fiscal intermediary might otherwise have deemed allowable for the service; and (b) the charge for another service is higher than the allowable charge, it should not be determined that the combined charges for the two services grouped together are allowable. Although the fiscal intermediary may give the physician or other person who rendered the service an opportunity to correct any billing error, the fiscal intermediary must not suggest to the physician or other person that the charge be increased for a given service.

There is an exception to this rule, involving multiple surgery. (See Section 3.7.)

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3. Inclusive Dates Shown For Period Covered by Services.

The fiscal intermediary may make an allowable charge determination without further development of the claim where one combined charge is indicated either on the claim forms or on the bill for the services rendered during an inclusive period such as from July 1 to July 15. This can be done only if the nature of each service rendered and the number of times each service or procedure was performed is clearly specified and the fiscal intermediary is quite certain, from its knowledge of physicians' charges, that the combined charge reported is no higher than the total of the charges for each individual item. For instance, a $100 charge for five office visits is consistent with a prevailing charge of $20 for an office visit. (Of course, the FI must also ensure that the total number of visits conforms to CHAMPUS limits.)

Where the claim does not clearly specify the nature and frequency of the service rendered, or where there is any question about whether the same service was rendered each time, the fiscal intermediary shall either obtain this information or use its judgment and general knowledge of the fee charging practices of physicians in the state to resolve the question. In either case, the fiscal intermediary must document in the claim file what information was obtained and/or what its judgment was.

For example, a claim may be submitted showing inclusive dates of July 10 - July 20 and a charge of $115 for visits made by a physician to an inpatient in a hospital. Assuming the physician visited the patient only once a day for 11 days, the average charge per visit would be $10.45. This unlikely per visit charge is an indication that the physician did not visit the patient 11 times during the 11-day period, or that the charges and services rendered during the inclusive period were not identical, or that the physician has made a package charge covering a particular period of treatment rather than specific services. In order to comply with Section 2 above and to make sure its allowable charge determination is correct, the fiscal intermediary (a) must either resolve this question through a contact with the patient or physician, or (b) it may exercise its judgment, and on the basis of its knowledge and experience with local fee charging practices, etc., determine that the physician has made a package charge and that the $115 charge consists of a $15 charge for the initial inpatient hospital visit and of a $10 charge made for each of ten subsequent inpatient hospital visits. If these charges satisfy the prevailing charge criteria, the fiscal intermediary may determine that they are allowable.

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Complete claim file documentation of the information obtained or judgement made by the FI is necessary to (a) help the FI develop its prevailing charge profiles, and (b) reflect that the FI has based its reimbursement of the claim on correct determinations of coverage and allowable charges.

Subject: PROVIDERS IN A TEACHING SETTING	Chapter: 3
	Section: 2
Authority: DoD 6010.8-R, Chapter VI.C.	Page: 2.1.1
Approval: Robert D Seamon for Director	Date: August 26, 1985

ISSUE

How are teaching physicians to be reimbursed?

POLICY

A physician or other individual provider who is paid by a hospital, either through employment or contract, shall not be directly reimbursed for services rendered to a CHAMPUS beneficiary. In such situations, reimbursement for the physician's services must be made to the hospital in order to prevent double payment.

Interns and residents may not be reimbursed directly by CHAMPUS for services rendered to a beneficiary when their services are provided as part of their employment (either salaried or contractual) by a hospital or other institutional provider. Interns and residents engaged in a formal training program, whether licensed or not, are considered to be "students." They should not be identified as the attending physician, they are not authorized to execute various certifications, and separate charges for their services should not be billed.

The amount payable for services of attending physicians supervising interns and residents in a teaching setting may be determined in accordance with the same criteria used for the determination of allowable charges for the services the physician renders to his other patients. Thus, the allowable charges for a service rendered in a teaching setting is subject to the limitations imposed by the prevailing charges.

Occasionally an institutional provider will establish charges for services rendered by a teaching physician. In such cases, CHAMPUS reimbursement should be based on the institutional provider's charges if they are allowable.

In some cases, teaching physicians of a hospital, or a skilled nursing facility to the extent applicable, may wish to adopt a uniform schedule of charges for the purpose of billing under CHAMPUS or Medicare for the services they provide as attending physicians in the

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teaching setting. Such schedule is submitted to the area Medicare carrier for its approval prior to submission of claims. Approval can be granted by the Medicare carrier on a service-by-service basis. Where approval is granted, the FI will utilize the same schedule. The uniform schedule of charges will be acceptable so long as the schedule charges (a) are not in excess of prevailing charges, and (b) are not expected to result in charges which would, in the aggregate, exceed the amount that would have been charged if the physicians in the group had billed individually. If as a result of using such a uniform schedule of charges, or for any other reason, an attending physician charges different amounts for services to patients in the teaching setting than for services to other patients, such charges will not be taken into account in determining the allowable charge for patients outside the teaching setting.

There are situations where a patient receives medical services in the teaching setting for which payment on the basis of allowable charges is not applicable. For example, there are instances where it is neither necessary from the standpoint of the medical needs of the patient nor appropriate from the standpoint of the continuing development of the resident's competence for there to be an attending physician. Whether or not a physician makes a charge under CHAMPUS for services to patients which involve the participation of residents or interns, the hospital can receive reimbursement on a billed charge basis from the FI for an appropriate share of the compensation it pays its residents and interns. If the teaching program is an approved program, reimbursement will also be available as a part of the billed charge of the hospital for an appropriate share of the compensation it pays to physicians for services in the teaching program which do not constitute services to patients and for other costs of educational programs conducted by the hospital.

Subject: NATIONAL HEALTH SERVICE CORPS PHYSICIANS OF THE PUBLIC HEALTH SERVICE	Chapter: 3 Section: 2
Authority: DoD 6010.8-R, Chapter VI.C.	Page: 2.2.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

ISSUE

What are the limitations on reimbursement of National Health Service Corps (NHSC) physicians?

POLICY

Physicians of the NHSC may be assigned to areas where there is a shortage of medical providers. These physicians are prohibited from accepting CHAMPUS payments, but the entities to which they are assigned are eligible for payment. Therefore, each FI shall maintain a list of all such physicians within the FI's service area to ensure that payments are not made directly to the physicians. The names of such physicians are available from the Public Health Service, Department of Health and Human Services.

Payment to the entities to which the NHSC physicians are assigned is to be made in accordance with the allowable charge procedures. Thus, NHSC physicians' charges should be recorded for future use in calculating prevailing charges.

Subject: MEDICAL GROUPS	Chapter: 3 Section: 2
Authority: DoD 6010.8-R, Chapter VI.C.	Page: 2.3.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

ISSUE

How are medical groups to be reimbursed?

POLICY

Allowable charges for services rendered by members of a group of professional providers who conduct their practices in a joint facility for the purpose of diagnosing and/or treating patients, etc., shall be determined on essentially the same basis as allowable charges for physicians in solo practice. The amount of reimbursement made under CHAMPUS will not be affected by any salary arrangements or other arrangements for the disposition of income made within the group.

Where all the members of a medical group make the same standard charge for similar services, the group has what is, in effect, a group charge. However, where the members of the group do not routinely make the same charges for similar services, the actual charges of each physician must be used in the determination of prevailing charges.

See section 9.1. if the group is a preferred provider organization (PPO).

Revision No:	Revision Date:

Subject: PROVIDERS WITH OFFICES IN MORE THAN ONE LOCALITY	Chapter: 3 Section: 2
Authority: DoD 6010.8-R, Chapter VI.C.	Page: 2.4.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

ISSUE

How are providers who have offices in more than one locality to be reimbursed?

POLICY

Physicians or other persons who maintain offices and render services in different locations, including different states, may have different actual charges for their services, depending on where the services were rendered. Where different states are involved, different prevailing charges may be applicable for identical services. In such instances, the fiscal intermediary must determine, to the extent feasible, the state in which the services were actually rendered, so that the correct prevailing charge can be used in making the allowable charge determination. This shall also be done where the provider's billing office is different from the location where the services were rendered.

Revision No: Revision Date:

Subject: ANESTHESIA	Chapter: 3
	Section: 3
Authority: DoD 6010.8-R, Chapter IV.C.2.g., C.3.h. and Chapter VI.C.	Page: 3.1.1
Approval: Robert D Seamon for Director	Date: August 26, 1985

ISSUE

How is CHAMPUS reimbursement for anesthesia services to be determined?

POLICY

1. Anesthesiologist Bills For Own Services.

The manner in which a fiscal intermediary applies the allowable charge criteria in processing claims for anesthesiologists' services should be consistent with the predominant billing methods of such physicians in its service area.

The American Society of Anesthesiologists and many state medical societies have developed relative value guides from which an anesthesiologist may determine the fee for a given service. These guides generally assign base unit values to the different surgical procedures and services listed and provide for additional units taking into account such factors as time, risk, age of the patient, etc. In most parts of the country, anesthesiologists have adopted the use of these relative value scales and conversion factors to establish charges for their services. Where this is the practice, the FI shall establish a prevailing charge conversion factor using the individual anesthesiologists' conversion factors in the same manner that prevailing charges are developed from actual charges. For example, where an anesthesiologist has billed $153 for an anesthesia service and the total of the relative value units for the service rendered (base, time, and other modifer) was 9, the physician has in effect used a $17 conversion factor. The prevailing charge conversion factor shall be computed by arraying the individual conversion factors in ascending order and weighting each by the frequency of services on which it was based. An actual amount in the array which is high enough to include 80 percent of the cumulative conversion factors shall be the prevailing charge conversion factor.

Units used by fiscal intermediaries (for base, time, and complicating factors) should be clearly established and conform as closely as possible to those used in billing for anesthesia services in the

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FI's area. The base units should be part of the fiscal intermediary's relative value system and should be established for each procedure for which anesthesia can be used. Time units should be consistent for all procedures. Whatever time units are used, any fraction of a unit should be considered a whole unit in determining reimbursement. The FI shall also have clearly established units for complications such as high-risk patients, age, etc. Thus, reimbursement for a procedure with no complications and which took 65 minutes (where the FI uses time units of 15 minutes) and which has a base value of 3 would be determined using a total of 8 units.

These procedures are to be followed for all anesthesia claims including epidural anesthesia.

The Fifth Revision of CPT-4 introduced approximately 200 general anesthesia procedure codes and descriptions which are based on body areas. The American Society of Anesthesiologists has developed a relative value system of base units for each of the codes. Since the CPT-4 anesthesia codes and descriptions are general, each may correspond to as many as thirty or forty surgical codes and descriptions. Thus, use of the codes could result in problems in coverage determinations and problems with duplicate claim edits. Moreover, they would result in inexact payment records. Since anesthesia is always associated with specific surgical procedures, there should be no problem in identifying the appropriate surgical procedure code for the anesthesia. Thus, anesthesia claims under CHAMPUS are to be based on the surgical procedure code combined with an anesthesia type of service. At no time are the CPT-4 anesthesia codes to be used.

Where the majority of anesthesiologists bill dollar amounts for services without any indication of the relative value units associated with their services, the fiscal intermediary must establish prevailing charge screens for such services in the same manner as for other physicians. Under this approach, any amounts for time, risk, age, etc. which are charged by a physician using a relative value scale and a dollar conversion factor to set the fee will not ordinarily be a basis for allowing amounts above the applicable prevailing charge. However, higher amounts can be allowed when they are justified by unusual circumstances or medical complications (see Section 4.1.).

Where a nurse anesthetist employed by an anesthesiologist provides services under the anesthesiologist's direct, personal, and continuous

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supervision, the anesthesiologist must include the charges for the employee's services in the bill for his services. The payment for the range of services provided by both the anesthesiologist and the anesthetist employee will be made to the anesthesiologist, or the patient in the case of nonparticipating claims, on an allowable charge basis.

2. Anesthesiologist Bills for Anesthesia Services Performed by a Person Not in His Employ.

The services of the anesthetist not in the employ of the physician, including the services of interns and residents, are covered as hospital services (except as detailed below). Also costs attributable to any compensation paid to an anesthesiologist for institutional services, such as teaching, supervision, and administration are similarly covered and are reimbursable to the hospital on the basis of other institutional charges. Payment can be made under CHAMPUS on an allowable charge basis for any direct patient care services personally rendered by the anesthesiologist.

If the care is otherwise eligible for benefits, anesthesia services rendered by a nurse anesthetist in private practice are payable under the following conditions:

(a) There is physician referral and the anesthesia service is performed under the supervision of a physician or dentist.

(b) The nurse anesthetist is operating within the scope of a valid license or certification in the jurisdiction where the anesthesia is rendered.

(c) The nurse is a Licensed Registered Nurse.

Where the anesthesiologist does not provide the complete range of anesthesia services (e.g., the operating room service was not personally performed by the anesthesiologist), the allowable charge for the physician's service should be less than the amount that could have been allowed had he personally performed the full range of services (e.g., it should not be equivalent to the relative value assigned to the full procedure in the relative value study used by the fiscal intermediary in its processing of CHAMPUS claims). For example, where the anesthesiologist personally examines the patient in order to determine the appropriate agent to be used by a nurse anesthetist, payment may be made for a consultation. If, however, the physician neither personally examines the patient nor administers the anesthesia, the services are not covered as physician professional services.

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Each fiscal intermediary should advise the anesthesiologists in its service area that when they are assisted by a nurse anesthetist who is not their employee, they must identify on their bills (or CHAMPUS claim forms) the direct personal services they themselves render to the patient, so that an appropriate judgment can be made as to what portion of the allowable charge for the total service can be allowed in the particular case. In some instances, the fiscal intermediary may have to consult with its medical staff before reaching the appropriate allowable charge determination.

Nothing in the foregoing precludes a physician who provides anesthesia services from establishing an "attending physician" relationship with a patient in a teaching hospital where the following criteria are met. In such cases, payment will be made on an allowable charge basis to the extent that the services are covered under CHAMPUS if the physician:

(a) Personally examines the patient;

(b) Is present at induction and emergence; and

(c) Performs other activities (with respect to the distinct segment of the patient's treatment) which distinguish an attending physician relationship.

The amount allowed as the allowable charge for the attending physician's services in the teaching setting must be appropriately reduced where he did not furnish in-person supervision of an intern or resident for the entire period during which anesthesia was administered. For example, where allowable charges for anesthesia services are determined by the fiscal intermediary on the basis of units (e.g., base units and time units) multiplied by a dollar conversion factor, an amount based on time units can be included in the allowable charge only for time the attending physician was present and furnishing either (a) direct personal services to the patient, or (b) in-person supervision of an intern or resident during the procedure. In this regard, however, there may be individual cases, considering such factors as the nature of the patient's condition, the experience of the residents, the proximity of the operating rooms, and the time spent in each operating room by the attending anesthesiologist, in which the fiscal intermediary's medical staff may determine that the attending anesthesiologist was present for sufficient time in each of two cases to warrant payment on an allowable charge basis for the full-time units in both cases. Claims files in such situations must be adequately documented and payment depends on an individually written determination by the fiscal intermediary's medical staff.

Subject: DURABLE MEDICAL EQUIPMENT/BASIC PROGRAM	Chapter: 3
	Section: 3
Authority: DoD 6010.8-R, Chapter IV.D.3.b.	Page: 3.2.1
Approval: Robert D Seaman for Director	Date: December 29, 1982

ISSUE

How is durable medical equipment to be reimbursed?

POLICY

1. Reimbursement procedures.

FI's shall take the necessary action to collect charge information from the suppliers of these items in its service area. In addition, its ongoing and continuing process of profile building and updating must provide for compiling the data on the actual charges for such items which may be obtainable from CHAMPUS claims as well as from its own business, Medicare profiles, and other sources whenever possible. This data shall then be used in development of the FI's prevailing charge screens.

For those supplies for which it would be impractical to develop prevailing profiles the FI shall obtain price lists from suppliers within its jurisdiction. Although price lists should be obtained directly from suppliers whenever possible, they may also be obtained from manufacturers. Such price lists must be those prices which were in effect on June 30 and December 31 of the 12-month period which is the data base period for the current profiles. The intent is to use a price list which can reasonably be assumed not to exceed the median of the prices charged during the data base period. Price lists are to be obtained and updated in accordance with the schedule for allowable charge profiles. Where it is not practical for the FI to obtain information for every single supplier in its service area or for every possible covered item, it should do the best it can to obtain the needed information from as many suppliers as possible, and at least with respect to those covered items which its own experience indicates are generally furnished to CHAMPUS beneficiaries.

2. Payment alternatives.

Payment for durable medical equipment can be made on either a rental or a purchase basis. Factors to be considered in determining which

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method to use include the allowable charge for purchase of the equipment, the allowable monthly rental charge for the equipment, the estimated duration of medical necessity for the use of the equipment, and the availability of rental equipment. In addition, the cost analysis must include a provision for the time value of money at the rate established quarterly and published in the United States Treasury Federal Regulations Manual bulletins and the Federal Register.

Reimbursement will be based on a determination of whether, given the estimated period of medical necessity, it would be more economical and appropriate for the equipment to be rented or purchased. In most cases, the total allowable CHAMPUS payment will not exceed the reasonable purchase cost of the equipment. An exception to this will be when, after an initial rental period predicated on anticipated brief medical necessity, a more prolonged period of medical necessity becomes apparent and purchase would now be less costly. Another exception involves rental payments made while the FI determines whether it would be more cost-effective to purchase the equipment. If the determination results in the outright purchase of the equipment, the beneficiary shall be notified of the determination and advised to purchase the equipment immediately. Any amount paid toward the rental of the item while a determination is being made should not be applied toward the maximum allowable amount for the purchase of the equipment. However, beginning thirty (30) days from the date of the FI's letter to the beneficiary regarding purchase of the DME, any charges for continued rental of the DME shall be applied to the maximum purchase price. Although objective measurement of the period of medical necessity will hold primary importance in the rental vs. purchase decision, subjective judgement will also be required in less clear-cut cases.

If the equipment is rented, the monthly payment will be limited to not more than 75 or 80 percent (dependent upon the applicable patient cost-share) of the allowable monthly rental charge. Monthly payments will be made until not more than 75 or 80 percent of the total allowable purchase price has been paid or medical necessity no longer exits (whichever occurs first).

3. Specific considerations.

Interest and Carrying Charges: Interest and/or carrying charges added by a supplier to his/her charge for durable medical equipment purchased on an installment basis may be reimbursed on an allowable charge basis if the following conditions are met:

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The interest and/or carrying charge is separately identified on the claim; and

It is the usual and acceptable practice in the state for suppliers to make such an extra charge; and

The practice of making an extra charge applies to all purchasers; and

The additional amount charged is not higher than the applicable state or local government interest limit.

If the interest and/or carrying charge meets these conditions, it will be accepted as part of the allowable charge. The total purchase price upon which reimbursement will be based then equals the allowable charge for the equipment plus the allowable interest charge.

Delivery and Service Charge: The allowable charge determination for rental or purchase of covered durable medical equipment must be based on the prevailing charges of suppliers in the locality who rent or sell similar durable medical equipment. If the suppliers customarily charge for delivery and service this must be recognized in the allowable charge determination. Where a supplier of covered durable medical equipment itemizes the delivery and service charge separately on the bill, it is the total charge (rental or purchase price plus delivery and service charge) that will be determinant for purposes of applying the prevailing charge.

Non-Cost-Advantageous Purchase: Payment may be made for the reasonable purchase price of DME when the equipment cannot be rented within a reasonable distance of the patient's current residence. All such claims approved for payment must be identified for possible review by OCHAMPUS Contractor Performance Evaluation personnel. Each must be completely and convincingly documented as to why the equipment could not be rented, and must reflect the actions undertaken by the beneficiary/sponsor in an effort to locate a source of such rental. While FI's will not be required to canvass all DME suppliers within a reasonable distance of the patient's residence, they must establish to their own satisfaction that rental is not available in that area, and that the beneficiary/sponsor made all diligent and reasonable efforts to rent the equipment. Depending on individual circumstances, this may necessitate contact with one or more representative and knowledgeable suppliers of DME.

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In addition, some items of durable medical equipment are not rentable and their purchase would be authorized.

Claim files for approved non-cost-advantageous purchase of DME must identify specifically the individual who approved such purchase, and must be sufficiently documented to permit reconstruction of the logic which led to the approval of the claim.

Lump-Sum Payment for Outright Purchase: When a determination is made that purchase of DME is cost advantageous, payment may be made based on the allowable charge for purchased DME in a lump sum with no specific dollar limit. FI's will ensure that the medical benefit to be gained by the patient is reasonable and commensurate with the acquisition cost of the DME. Because definitive screens for this criterion cannot be provided, judgement must be exercised, and questionable situations should be referred to OCHAMPUS.

Termination of eligibility: When the sponsor will be discharged before the period of medical necessity will end, evaluation, in terms of expected necessity, might show that purchase would be less costly, but examination of potential rental costs through eligibility expiration date may reveal that rental would be the preferred method. It is not the intent of the Program to meet the medical needs of beneficiaries beyond the ending date of their eligibility.

Subject: OXYGEN AND RELATED SUPPLIES	Chapter: 3
	Section: 3
Authority: DoD 6010.8-R, Chapter IV.D.3.d.	Page: 3.3.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

ISSUE

How are oxygen and supplies related to the use of oxygen to be reimbursed?

POLICY

CHAMPUS payments may be made for oxygen and for the rental of the oxygen tank when the use of oxygen is determined to be medically necessary, and in accordance with the CHAMPUS Regulation.

Usually, when a dealer supplies a tank of oxygen, the claim covers both the rental of the tank and purchase of the oxygen.

The tank rental charge is usually a monthly charge and shall be determined by the FI using the regular allowable charge methodology. The FI shall allow a monthly rental charge on only one tank each month. This would include situations where the tank is replaced during the month because of damage, malfunction, or because the oxygen is used up, etc. In cases where a beneficiary requires more oxygen during a month than is contained in one oxygen tank, payment for the extra oxygen should be allowed, but no extra rental charge for the oxygen tank should be allowed for the remaining days of the month. In other words, where the FI receives a bill for the rental of two tanks of oxygen during a month, the allowable rental charge should not exceed the amount allowable for one tank used during the month.

Where claims are received for partially used tanks, the FI should, to the extent possible, pay only for the oxygen used. Where a tank of oxygen is used up before the month is over and the empty tank is returned to the supplier, the rental charge allowed should be prorated, to the extent practicable, based on the number of days in the month the tank was used by the beneficiary.

Subject: LABORATORY SERVICES	Chapter: 3 Section: 3
Authority: DoD 6010.8-R, Chapter IV.C.2.j.	Page: 3.4.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

ISSUE

How are laboratory services to be reimbursed?

POLICY

For purposes of the instructions that follow, a diagnostic laboratory test, whether performed in a physician's office, in an independent laboratory, or in another laboratory, is to be treated by the FI as a laboratory service. The term, "another laboratory," refers to such examples as a reference laboratory that performs services only for other laboratories, or a hospital laboratory functioning as an independent laboratory. Also, when physicians and approved laboratories perform the same test, whether manually or with automated equipment, the services will be deemed similar and the respective charges of all physicians and approved laboratories for that test must be commingled in the computation of the prevailing charge in the state for the test.

1. Determining Prevailing Charges for Single Laboratory Tests.

No distinction should generally be made in determining allowable charges for laboratory services between (a) the sites where the service is performed, i.e., physicians' offices or other laboratories; or (b) the methods of the testing process used, whether manual or automated.

Therefore, when only one test is performed for a patient, the prevailing charge for the single laboratory test shall be derived from the charges (weighted by frequency) of both the physicians and other laboratories that perform the test in the state, including tests performed manually or with automated equipment. The automated equipment charges to be used are those for a single test that is not performed as part of a battery of tests.

The charges of physicians include charges for tests performed in their own offices as well as charges billed for tests performed by other laboratories. The charges of other laboratories include only those charges billed to the general public but not to physicians.

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2. Laboratory Tests Utilizing Automated Equipment.

Clinical laboratory tests are covered under CHAMPUS if they are reasonable and necessary for the diagnosis or treatment of an illness or injury. In the case of multi-channel automated laboratory determinations, however, the physician is not free to specify those tests the patient needs and there is normally only one charge for the battery of tests. The delivery of the services in this manner generally is much more economical than if the tests are performed individually.

Where at least one test of an initial automated battery of tests can be reasonably related to a specific complaint or symptom, the allowable charge for the complete initial battery of tests is payable. The charge for an initial battery of tests cannot exceed the total of the allowable charges for all the tests if purchased individually. In arriving at an allowable charge determination, the prevailing charge profile shall reflect only charges for automated batteries of tests and not the charges for the tests when performed individually. Of course where a physician bills separately for individual tests of a battery, no more than the allowable charge for the battery can be allowed.

The following list contains some of the tests which can be and are frequently done as groups and combinations on automated multichannel equipment:

Albumin
Bilirubin, direct
Bilirubin, total
Calcium
Carbon dioxide content
Chlorides
Cholesterol
Creatinine
Globulin
Glucose (sugar)
Lactic dehydrogenase
Phosphatase, alkaline
Phosphorus
Potassium
Protein, total
Sodium

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Transaminase, glutamic oxalacetic (SGOT)
Transaminase, glutamic pyruvic (SGPT)
Urea nitrogen
Uric Acid

The costs of a battery of tests is ordinarily so low as compared with the costs of tests performed individually that FI's are not expected to scrutinize bills for such batteries individually with regard to the coverage of the test or utilization aspects of the service. FI's shall, however, review bills where the cost of the battery is relatively high or where a large volume of continuing batteries of tests raises a question about repeat tests. The charge for the battery of tests must, however, be compared to the allowable charge screens in each instance.

Where a battery of tests is repeated, only those individual tests in the battery which are required to follow the patient's progress are covered. Follow-up tests performed at a frequency greater than is necessary for the reasonable medical management of the patient's condition would not be covered. Payment is not to exceed the prevailing charge for the individually covered tests whether ordered individually or in a battery of tests. For example, the use of the 12-channel serum chemistry test to determine the blood sugar level in a proven case of diabetes would be unallowable because the results of a blood sugar test performed separately would provide the essential information. Normally, the allowable charge for a blood sugar test would be lower than the allowable charge for the automated battery of tests. In no event, however, may payment for the covered tests exceed the allowable charge for the battery.

Where no test in an automated battery of tests performed initially or as a follow-up measure can be reasonably related to a specific complaint or symptom, no payment will be allowed for the battery.

3. Physician Billing For Tests Performed By An Independent Laboratory.

It is the responsibility of the FI to determine whether the laboratory services were performed in the office of the physician or by another laboratory. If they were performed by another laboratory, payment may be made only if the laboratory performed tests in the specialties for which it is certified under the Program. When a laboratory performs a test for which it is certified but the ordering provider bills for the

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service, the allowable charge shall be based on the prevailing charge for that test in the state where the billing provider's office is located.

4. Laboratory Tests Performed Out-of-State and Billed by a Laboratory with Out-of-State Billing Address.

Frequently a provider utilizes a laboratory which is located outside the state in which the provider is located. Similarly a laboratory may have a billing address in a state different from the state in which the laboratory is located. When this situation arises, the FI with jurisdiction for the state in the billing address is to process the claim.

In those situations where laboratory work is actually performed by a laboratory which is out of jurisdiction but which is being billed by a provider within the jurisdiction of the FI, the prevailing profiles applicable to the billing provider shall be used.

5. Separate Drawing or Collecting and Handling Charges by Physicians.

Separate charges made by physicians for the drawing or collecting and handling of specimens (e.g., drawing a blood sample through venipuncture), may be allowed only if: (a) it is the accepted and prevailing practice among physicans in the state to make separate charges for these services; and (b) it is the customary practice of the physician performing such services to bill separate charges for them; and (c) the laboratory test for which the specimen was obtained is not performed in the physician's office.

As used in the context of this instruction, the "drawing" or "collecting" of a specimen refers to those cases in which the physician or his nurse or other paramedical assistant in his employ personally extracts a specimen from the patient. For example, no allowance should be made for collecting a urine specimen that the patient either brings to the physician's office or produces while in the office. On the other hand, a urine specimen extracted through catheterization would meet the foregoing rule. Similarly, a small amount may be allowed for "handling," but only if the physician actually incurs an expense in preparing and shipping a specimen to a laboratory.

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The billing for specimen collection and handling must be a separate, identifiable charge before the special allowance is made. If the physician's bill merely contains charges for the particular test(s) performed by the outside laboratory, no separate payment shall be made for specimen collection and handling, even though the physician has customarily billed for these costs in the past and it is the prevailing medical practice in the state to bill for such costs.

When an allowance would be proper under the above rule, the total amount allowed for the combined drawing/collecting/handling services (including materials and supplies used) shall not exceed $7. This nominal amount is deemed to be allowable since paramedical personnel are normally capable of providing, and often do provide, the services. Only a single $7 allowance for drawing or collecting and handling charges may be made even if more than one specimen is drawn or collected from a patient on a given occasion. However, higher amounts may be allowed when appropriate in unusual circumstances such as highly complex collection procedures. (See Section 4.1.)

6. Referral Laboratory Services.

The following guidelines shall be used by FI's in processing claims which involve laboratory tests that have been referred by one independent laboratory to another. For purposes of these instructions, the term, "referring laboratory," means the laboratory that sends a specimen to another laboratory which performs the prescribed test. The latter laboratory is the "reference laboratory."

The FI may allow a referring laboratory up to $7 for the costs it incurs for packaging and shipping a specimen(s) to a reference laboratory, provided it is the customary practice of the referring laboratory and the prevailing practice among other referring laboratories in the state to bill separately for these costs. Either one of the following conditions must be met before such allowances can be paid:

(a) If a referring laboratory performs a reasonable and necessary test for which it is certified and also forwards a portion of the specimen to a reference laboratory for the performance of a test which the reference laboratory is certified to perform but which the referring laboratory is not able to perform; or

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(b) If a referring laboratory forwards a specimen to a reference laboratory for the performance of a test which both laboratories are certified to perform but which the referring laboratory is temporarily unable to perform, e.g., because of a breakdown of equipment.

No allowance shall be made for any collection or handling charges where (a) the referring laboratory merely draws or collects a specimen from a patient for a test it is not certified to perform and ships it to a properly certified reference laboratory for testing, and (b) the referring laboratory performs no covered service on a portion of that specimen.

In determining the proper program allowances for the laboratory tests when the referring laboratory and the reference laboratory are serviced by different FI's, the instructions in Section 4 above are to be followed. Thus, FI jurisdiction is determined by the billing address of the reference laboratory.

7. Drawing of Specimen By a Laboratory Technician From a Nursing Home Patient or a Homebound Patient.

Except for the services incident to a physician's services performed under his general supervision, a nominal amount may be allowed when an FI determines it was medically necessary for a laboratory technician to draw a specimen from either a nursing home patient or a homebound patient in connection with a covered laboratory test. The technician must personally draw the specimen from the patient for a laboratory test that is determined to be reasonable and necessary before the technician's service would be payable. Medical necessity would not exist where the technician merely performs a messenger service, such as picking up sputum or urine specimens, or where, in the case of a nursing home patient, a nurse draws the specimen which the technician then transports to the laboratory for testing. (In claims involving patients in skilled nursing facilities, the FI's should presume, absent information to the contrary, that the specimens are collected by nursing personnel, and therefore the laboratory is not to be paid for this service.)

Payment for this service shall only be made where it has been the practice among independent laboratories in the locality and the practice of the laboratory performing the test to make a separate charge when a technician is required to draw the specimen from either a nursing home

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patient or a homebound patient. If such charges are part of the laboratories' billing practices in a state, the FI shall develop a schedule of allowances for the technicians' services.

FI's should consult with local and national associations of independent laboratories to resolve any differences that may arise over this payment method. The amounts allowed may not exceed the following limits:

(a) An amount not in excess of $7, may be allowed for a technician's service in drawing a specimen from one patient in a nursing home or from a homebound patient.

(b) An amount, not in excess of $5 per patient, may be allowed when a technician draws specimens from more than one patient during the same nursing home visit.

(c) In both of the above situations, the amount(s) allowed covers the travel expenses of the technician, as well as the specimen drawing service and the materials and supplies used. Exceptions to this rule may be made by an FI when it is clearly established that the payment is inequitable in light of the distances the technician must travel to perform the service. In general, independent laboratories in metropolitan and urban areas are able to schedule their nursing home visits to coincide with their routine pickups of specimens from physicians' offices and therefore no mileage or travel charges should be allowed in addition to the above amounts. On the other hand, nursing home patients or homebound patients in rural areas may not be easily accessible to the independent laboratories and the servicing FI's may determine, on an individual consideration basis, that a travel expense allowance (in addition to the nominal allowance for drawing the specimen) would be merited. (See Section 4.1.)

8. Laboratory "stat" charges.

On occasion the results of a laboratory test are needed faster than would be possible under routine processing. An additional amount for such "stat" processing is reimbursable. The FI is to ensure "stat" processing is justified and process the claim on an individual consideration basis. (See Section 4.1.)

Subject: AMBULANCE SERVICES	Chapter: 3
	Section: 3
Authority: DoD 6010.8-R, Chapter IV.D.3.e.	Page: 3.5.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

ISSUE

How are ambulance services to be reimbursed?

POLICY

Allowable charge/cost methodology will be used to adjudicate ambulance claims. Information from ambulance companies in each service area will be used in the development of prevailing base rate screens. In FI service areas where suppliers routinely bill a mileage charge for ambulance services in addition to a base rate, an additional payment based on prevailing mileage charges may be allowed.

Reusable devices and equipment such as backboards, neckboards and inflatable leg and arm splints are considered part of the general ambulance services and shall be included in the cost of, or charge for, the trip.

A separate cost or separate reasonable charge based on actual quantities used may be recognized for nonreusable items and disposable supplies such as oxygen, gauze, dressings and disposable linens required in the care of the patient during his trip.

See Volume 1, Chapter 7, Section 2 of the Policy Manual for additional specific information on the coverage of ambulance services.

Subject:
LEGEND DRUGS AND INSULIN

Chapter: 3

Section: 3

Authority:
DoD 6010.8-R, Chapter IV.D.3.f.

Page:
3.6.1

Approval: Deputy Director

Date:
August 26, 1985

ISSUE

How are legend drugs and insulin to be reimbursed?

POLICY

1. Pricing of legend drugs (those drugs that require a prescription by law) and insulin will depend on the claimant: beneficiary (consolidated drug claim) or provider (vendor pharmacy or physician).

2. For beneficiary submitted claims, reimbursement is to be based on the billed charge. For vendor pharmacy submitted claims, the allowable charge for outpatient prescription drugs paid to a vendor pharmacy will be the acquisition cost (taking into account the strength, quantity, and generic/nongeneric status) plus an amount determined by OCHAMPUS ($3.00) for each prescription. This fixed fee does not apply to insulin.

3. The acquisition cost of drugs for vendor pharmacies, physicians, etc. is to be determined from the _Drug_ _Topics_ _Red_ _Book_. In all cases the FI is to use the latest annual edition of the _Red_ _Book_ as well as the monthly updates.

4. When a physician submits charges for legend drugs dispensed directly to the patient, the charges may be paid at cost to the physician only. No administrative or professional fee is allowed.

5. Allowable charge screens for injections shall be based on: (a) a flat $5 allowance for the service of the physician (or office nurse) in providing the injection; plus (b) the current cost of the most frequently administered dosage of the drug, as reflected in the _Drug_ _Topics_ _Red_ _Book_, and the cost of supplies such as syringes and needles. (The price of the smallest unit of packaging offered by the manufacturer that will include the most frequently administered dosage of the drug must be used in this regard.) However, in cases involving unusual circumstances, an additional allowance above the $5 amount for the physician services may be considered provided proper documentation is supplied. Also, where the claim is documented to

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indicate that the dosage administered and the cost of the drug used were higher than the drug cost that would be applicable to the most frequently administered dosage, the higher drug cost may be allowed to the extent that it is reasonable.

6. If the fiscal intermediary knows that the sole purpose of an "office visit" was for the patient to receive an injection, payment may be made only for the injection (if it is covered). For example, the FI would reimburse for a 90030, minimal service (under CPT-4). Allowance of a separate additional charge for an "office visit" would not be warranted where the services rendered did not really constitute a regular office visit.

7. All injection claims submitted to a fiscal intermediary should include the specific name of the drug used. Identification of the drug will enable the fiscal intermediary to correctly pay for the services rendered and help establish meaningful injection screens.

8. Where the total charge made for an injection (i.e., for the service of the physician and/or his office nurse in providing the injection, and for the cost of the drug and supplies used) does not exceed $7, the actual charge made may be determined to be an allowable charge without any further determination of the drug cost through
* use of the Drug Topics Red Book. Thus, where the actual cost of the *
drug used was less than $2, use of the $7 tolerance would allow room for some cushioning to offset losses due to spoilage and spillage. If the FI requests, but does not receive, an itemization of costs for supplies, drug, and administration service, and if this information cannot be obtained from the Red Book or Blue Book, the FI is not to deny that line item but is to allow up to the $7.00 tolerance amount. Of course, in no case may the allowable charge exceed the actual charge made for an injection.

9. Injections such as those that require the precise placement of a needle into inflamed, painful, or target areas or the injection of dangerous drugs may require that only a physician provide this service. Consequently, injections of this nature should not be considered routine, and appropriate allowances shall be made. In these instances, the fiscal intermediary may establish prevailing charge screens to reflect the actual practice of physicians in a state.

Subject: SURGERY	Chapter: 3
	Section: 3
Authority: DoD 6010.8-R, Chapter IV.C.2.a., C.2.b., C.3.a., C.3.c., and C.3.d.	Page: 3.7.1
Approval: Deputy Director	Date. August 26, 1985

ISSUE

How is surgery to be reimbursed?

POLICY

1. Multiple Surgery.

a. Multiple surgical procedures for related conditions shall be reimbursed under the following rules. According to section C.3.a. of chapter IV, DoD Regulation 6010.8-R, where multiple surgical procedures are for related conditions (i.e., performed through the same surgical approach or opening), benefits shall be limited to that part of the surgical care for which the greatest amount is payable. This places the onus on the provider for billing the various procedures either as a lump sum or consonant with the FI's prevailing profiles. To alleviate this problem, whenever an FI receives an itemized claim for related multiple surgical procedures, the FI must apply the prevailing profile for the major procedure to the sum of the physician's charges for the separate procedures. (The major procedure is to be determined by the allowable amount rather than the relative value units.) Data which is distorted because of this procedure must not be entered into the data base. Where two or more procedures are billed separately but are commonly billed as a single procedure with a greater allowable charge, the greater allowable charge is to be used in determining reimbursement for the claim.

b. Multiple surgical procedures for unrelated conditions shall be reimbursed under the following rules. Where multiple surgical procedures are for unrelated conditions, benefits shall be limited to 100% of the allowable charge for the major surgical procedure and the lesser of the billed charge or 50% of the prevailing charge for the other procedures. If the multiple surgical procedures involve the fingers or toes, benefits for the third and subsequent procedures are to be limited to the lesser of the billed charge or 25% of the prevailing charge. Since this procedure can create the same billing problems as for related procedures, FI's are to use the sum of the

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charges in determining reimbursement as is required for related procedures. Thus, the allowable charge for three unrelated surgical procedures (not involving fingers or toes) would be the lower of the sum of the billed charges or the sum of 100% of the prevailing charge for the major procedure and 50% of the prevailing charge for each of the other two procedures.

c. When more than one surgeon acts as a primary surgeon for multiple procedures during the same operative session, the services of each may be covered, subject to the following considerations:

(1) The medical necessity for the separate skills of each surgeon is clearly documented. If the total surgical service could have been, and customarily is, performed by a single surgeon, payment will be made according to 1 and 2 above.

(2) All claims for multiple primary surgeons require medical review by the FI.

(3) Each separate surgeon's service is to be reviewed as a total service in its own right. If one or more of the individual surgeons performs multiple procedures, the above provisions must be applied to that surgeon's claim.

(4) Payment may not be made to any of the primary surgeons for assisting any of the other primary surgeons.

2. Assistant Surgeons.

The allowable charge for an assistant surgeon (where such services are covered) is to be the lower of the billed charge or 20% of the prevailing charge for the surgery involved. Where an assistant surgeon is involved in multiple surgery, the same procedures used for determining reimbursement for the primary surgeon shall be used in determining reimbursement for the assistant surgeon.

3. Post-operative care.

Normally the charge for surgery includes routine follow-up care. This care may include hospital visits as well as related office visits. Relative value studies often specify the number of days

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during which routine follow-up care can be expected. If a physician itemizes the surgery charge and the charges for routine post-operative care, the FI shall use the total of the charges as a single charge for which the allowable charge is determined. Of course, post-operative complications, etc., may justify unusual care and a greater allowance (see Section 4.1.).

4. Pre-operative care.

Pre-operative care rendered in a hospital when the admission is expressly for the surgery is normally included in the surgery charge. If it is itemized the FI must total the charges in order to determine the allowable charge. This also applies to routine examinations in the surgeon's office where such examination is performed to assess the beneficiary's suitability for the subsequent surgery.

* 5. Second opinion. *

* a. Claims for patient initiated, second-physician opinions pertaining to the medical need for surgery may be paid. Payment may be made for the history and examination of the patient as well as any other covered diagnostic services required in order for the physician to properly evaluate the patient's condition and render a professional opinion on the medical need for surgery. *

* b. In the event that the recommendations of the first and second physician differ regarding the medical need for such surgery, a claim for a patient-initiated opinion from a third physician is also reimbursable. Such claims are payable even though the beneficiary has the surgery performed against the recommendation of the second (or third) physician. *

* c. Payments for patient-initiated, second (or third) opinions will be based on the reasonable charges for consultations (and related services) of a comparable level of care. *

Subject: OBSTETRICAL CARE	Chapter: 3 Section: 3
Authority: DoD 6010.8-R, Chapter IV.C.2.1.	Page: 3.8.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

ISSUE

How is obstetrical care to be reimbursed?

POLICY

1. General.

Following each update of prevailing fee screens, the fiscal intermediary will utilize the updated global maternity care fee determination. Natural childbirth classes and training will be reimbursed only if included as a part of the global fee of the physician, and subject to prevailing fee limitations based on the actual charge data that combine the global fees of physicians that do not provide natural childbirth training with those that do provide the classes.

A global maternity fee may be reimbursed only if the physician, or an alternate reimbursed by the physician, supervises or performs the delivery as well as the prenatal and postnatal care. Moreover, while a physician may itemize the various components of a global fee where a physician (or group) provides all the services, reimbursement cannot exceed the prevailing charge for a global fee.

The global fee is to include all professional services normally provided during a maternity episode. An additional allowance can be made for pregnancy testing, since that is a medical service separate from, although related to, the maternity episode.

Where there is no actual area prevailing charge for a normal delivery without prenatal or postnatal care, the allowable charge is to be the lower of the billed charge or 80% of the prevailing charge for a global fee.

(See Section 11.2. for maternity cost-sharing provisions.)

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2. Prenatal care.

Where prenatal care is billed separately from the delivery charge, procedure code 59420 is to be used to identify a charge for the entire prenatal episode and procedure code 59421 is to be used to identify individual prenatal visits or services. Where more than one visit is billed on a single claim using procedure code 59421, the bill must indicate the number of visits and/or services involved.

The allowable charge must be determined for each bill submitted for prenatal care. If the bill is for an entire episode of prenatal care (59420), the FI is to allow the lower of the billed charge or 30% of the global fee. If the bill is for a single or several visits (59421), however, it would be impractical to apply the 30% limitation, and the FI should simply determine the allowable charge for each such visit. If the FI does not have a profile for a single prenatal visit, it can use the profile for a comparable office visit (e.g. 90050) as a basis for determining the allowable charge.

3. Postnatal care.

Postnatal care consists of one or more follow-up office visits. It may be reimbursed separately only when it is rendered by a physician (or group) totally unrelated to the provider who performed the delivery. In such a case, postnatal care shall be reimbursed as individual office visits using the profile for postnatal care (59430) or the profile for a comparable office visit.

Subject: SPEECH THERAPY	Chapter: 3 Section: 3
Authority: DoD 6010.8-R, Chapter VI.E.3.	Page: 3.9.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

ISSUE

How are profiles to be developed for individual speech therapy?

POLICY

Fiscal intermediaries are to be able to differentiate between speech therapy sessions of 30 minutes and 60 minutes in their reimbursement procedures. Since all individual speech therapy is to be coded as procedure 92507, the prevailing charge developed for speech therapy is to be for a 30-minute session. A 60-minute session is to be considered two units of speech therapy.

POLICY CONSIDERATIONS

This applies only to individual speech therapy. Group speech therapy is generally provided in 90-minute sessions and a separate prevailing charge can be developed for it under procedure code 92508.

Subject: REFRACTIVE SERVICES	Chapter: 3
	Section: 3
Authority: DoD 6010.8-R, Chapter IV.G.51 and Chapter VI.E.3.	Page: 3.10.1
Approval: Robert D Seamon for Director	Date: August 26, 1985

ISSUE

How are refractive services to be reimbursed and how can they be excluded from payment when they are not covered but are billed combined with other covered services?

POLICY

Covered refractive services (see Policy Manual, Volume 1, Chapter 1, Section 16) are to be reimbursed based on a prevailing charge developed for such services.

Where refractive services are not covered, but the charge for the refractive services is included in the charge for other covered eye procedures, the fiscal intermediary must exclude a portion of the total charge before making the allowable charge determination. Whenever possible, the fiscal intermediary should use its prevailing charge for refractive services as the amount by which to reduce the total charge.

Where there is no prevailing charge for refractive services, the following guidelines can be used. In a comprehensive ophthalmological examination (e.g., an initial eye examination), the value of the refractive procedures can be set at 20 percent of the total charge. In a followup examination, the value of the refractive procedures can be set at one-third of the total charge.

Revision No: Revision Date:

Subject: INDIVIDUAL CONSIDERATION CASES	Chapter: 3
	Section: 4
Authority: DoD 6010.8-R, Chapter VI.E.3.a.(5)	Page: 4.1.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

ISSUE

Under what situations can more than the prevailing charge be reimbursed for items or services?

POLICY

When unusual circumstances or medical complications require additional time, effort or expense, the provider may request payment of a charge or fee that exceeds the prevailing charge. This charge may be determined to be allowable where the circumstances or medical complications support an additional charge. These special circumstances need not necessarily involve additional medical or surgical procedures to be considered in the allowable charge determination.

The fiscal intermediary will determine whether or not it is acceptable medical practice to charge the extra amount. This determination will be based on whether or not it is acceptable medical or medical service practice in the state to make an extra charge in such cases. Of course, the mere fact that the physician's or other provider's usual charge is higher than the prevailing charge would not of itself justify allowance of the higher charge. At times, the FI may wish to consult its medical review staff or the local medical society for any information which might be helpful in making this determination.

Whether all or part of the additional amount charged is allowable will have to be determined by the fiscal intermediary based on its knowledge of all pertinent facts including (1) the usual additional charge, under the circumstances, of the physician or other person rendering the service; (2) the prevailing charging practices under such circumstances of physicians and other persons in the state; and (3) the additional time spent or expenses incurred by the physician or other person rendering the service, etc. These determinations are to be made on a case-by-case basis.

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Claims shall be pended and reviewed for accuracy of the procedure code and number of services if: (1) there is reason to believe a submitted charge which exceeds the prevailing charge may be justified; or (2) if the submitted charge is 50% or less or one hundred fifty percent (150%) or more than the allowed amount and the difference is not the result of an identifiable clerical error. FI's desiring to apply more stringent controls may do so.

While they do not cover all possible situations, the following guides shall be applied in determining the allowable charge when unusual circumstances or medical complications are present:

(1) Medical complications. Any claim which indicates there were actual medical complications which required time and effort over and above the normal range for the service shall be reviewed for possible allowance of charges in excess of the prevailing charge.

(2) Travel and Mileage Charges. An additional fee for travel on the basis of mileage might be justified if the physician or other person makes an extra charge for mileage to his patients in general when travel is required, and if this is accepted medical practice in the state.

Subject: PENALTY CHARGES FOR LATE PAYMENT	Chapter: 3 Section: 4
Authority: DoD 6010.8-R, Chapter IV.C.1.	Page: 4.2.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

ISSUE

Can penalty charges for late payments be allowed under CHAMPUS?

POLICY

Penalty or interest charges imposed on a beneficiary by a physician or supplier because of failure to make timely payment on a bill are not covered under CHAMPUS and are not included in the allowable charge determination.

Provider administrative expenses such as charges for claims completion, furnishing medical records, etc., are not to be included in the allowable charge determination.

Revision No:	Revision Date:

CHAMPUS POLICY MANUAL
VOLUME II

6010.47-M

Chapter: 3

Subject:
RARE OR UNUSUAL PROCEDURES

Section: 4

Page:
4.3.1

Authority:
DoD 6010.8-R, Chapter VI.E.3.a.

Date: August 26, 1985

Approval: Robert D Seaman for Director

ISSUE

How is the allowable amount to be determined for rare or unusual procedures for which there is no prevailing profile?

POLICY

FI's will occasionally be confronted with situations in which a new or rare procedure is performed and for which it is difficult to obtain information on prevailing charges. In such situations the fiscal intermediary, in order to make the allowable charge determination, shall (1) obtain data, if possible, on the charges made for the unusual or rare procedure in other states similar to the state in which the service was rendered; or (2) consult with its own medical review staff or the local medical society regarding the appropriate charge to be made for this procedure. A relative value scale may be used together with available information about the prevailing charges for more frequently performed services in the state in order to fill gaps in the data available to the fiscal intermediary.

In some instances the procedure may be one that CHAMPUS has just begun to cover but which has been performed within the particular state for some time. In such a case the FI should endeavor to base its allowance on data from the appropriate profile data base period.

Where the fiscal intermediary cannot obtain sufficient information through its knowledge of medical care charges in other states, it must consult with any medical authority that it would consider helpful, such as the medical personnel on its staff, the local or state medical society, or hospital medical personnel, etc. In assessing the value of the procedure, the medical personnel must take into consideration: (1) its complexity; (2) the surgical skill required; (3) the time needed to perform the procedure; and (4) the prevailing charges in the state for other procedures of comparable complexity. The fiscal intermediary shall then base its judgment as to the allowable charge for a given service on the best available medical opinion and information on prevailing charges. Such determinations must be documented in the claim file.

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Revision Date:

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It is recognized that some rare or unusual procedures cannot be priced by the allowable charge methodology and must be paid as billed. Explanations of the rationale for paying as billed must be documented.

Subject: PAYMENT FOR PROFESSIONAL/TECHNICAL COMPONENTS OF PATHOLOGY AND RADIOLOGY SERVICES	Chapter: 3 Section: 4
Authority: DoD 6010.8-R, Chapter IV.C.2.i. and C.2.j.	Page: 4.4.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

ISSUE

How are professional and technical components of pathology and radiology services to be reimbursed?

POLICY

Frequently charges for pathology and radiology services are split between the professional (physician) and the technical (equipment) components. Wherever possible, separate profiles are to be developed for each component. When this is done and a bill is received for the total service, the sum of the two components can be used as the prevailing charge.

There are cases where separate profiles cannot be developed for each component but a profile is developed for the total service. When the FI only has a prevailing charge for the total service but it receives a bill for one component, the allowable charge shall be 60% of the prevailing charge for the technical component and 40% of the prevailing charge for the professional component.

Some laboratory services do not require a professional interpretation, generally because the test simply indicates the presence or absence of a particular condition. Moreover, the results of blood tests, urinalyses, etc. are generally utilized in the context of all clinical information available in the patient's chart, and the related physician services are routinely included in fees for hospital visits, consultations, and other medical services. For these laboratory services the profile is to be assumed to cover the technical component only. If the professional component is separately billed it shall be denied as not medically necessary. Similarly, the FI shall deny claims for professional interpretation of laboratory tests when billed by anyone other than the attending, or a consulting, physician. The key is that professional interpretation for laboratory tests can only be paid to a physician who: (1) has access to the patient's medical records, and (2) can alter the patient's course of treatment based on the test results.

Revision No:	Revision Date:

Subject: PSYCHOTHERAPY PROFILES	Chapter: 3 Section: 4
Authority: DoD 6010.8-R, Chapter VI.E.3.a.	Page: 4.5.1
Approval: Robert D Seaman for Director	Date: April 1, 1983

ISSUE

What profiles should be developed for psychotherapy?

POLICY

Fiscal intermediaries are required to develop separate profiles for each class of provider which renders psychotherapy. The classes consist of psychiatrists, psychologists, and all others (licensed psychiatric social workers, MSWs, marriage and family counselors, pastoral counselors, and licensed psychiatric nurses).

Since there are differing coverage limitations for inpatient and outpatient psychotherapy the setting must be identified on the claim and the FI must process them separately. Moreover, inpatient psychotherapy generally involves more acute care as well as more extensive services, including overall patient management and supervision of the milieu team. As a result of the above, charges for inpatient psychotherapy are frequently higher than charges for outpatient psychotherapy. In those states where these differences are common, FIs should also develop separate profiles for inpatient as well as outpatient psychotherapy.

Revision No: 1 Revision Date: August 26, 1985

Subject: PAYMENT LEVELS FOR ADJUSTMENTS	Chapter: 3
	Section: 4
Authority: DoD 6010.8-R, Chapter VI.E.3.	Page: 4.6.1
Approval: Robert D Seamon for Director	Date: August 26, 1985

ISSUE

What profiles are to be used for adjustments?

POLICY

The profile in effect at the time the adjustment is made is to be used to determine the allowable charge for the adjustment. Only those line items in question are to be adjusted--not the entire claim.

Revision No. 1
Revision Date:

Subject: INSTITUTIONAL REIMBURSEMENT - GENERAL	Chapter: 3 Section: 5
Authority: DoD 6010.8-R, Chapter VI.E.1.	Page: 5.1.1
Approval: Deputy Director	Date: August 26, 1985

ISSUE

What procedures may be used in determining payments for institutional services?

POLICY

CHAMPUS Fiscal Intermediaries have discretion in the development of allowable cost and charge controls for reimbursement of institutional care under CHAMPUS. Development of voluntary alternatives, such as negotiated rates, cost reimbursement, or prospective reimbursement is encouraged. The principle of making the determination on the basis of the "reasonable cost" of providing the service must prevail, however, irrespective of the method. This section provides general guidelines and policies which are to be followed by FI's in
determining the allowable costs/charges for institutional services *
* provided to CHAMPUS beneficiaries. Unless otherwise directed in *
* this Chapter 3, reimbursement for all institutional providers shall *
* follow the procedures set forth for hospitals on pages 6.1.1 and *
* 6.1.2 of this Chapter.

Revision No: 1	Revision Date: February 26, 1986

Subject: HOSPITAL REIMBURSEMENT - BILLED CHARGES/ SET RATES	**Chapter:** 3 **Section:** 6
Authority: DoD 6010.8-R, Chapter VI.E.1.a.	**Page:** 6.1.1
Approval: Robert D Seaman for Director	**Date:** August 26, 1985

ISSUE

How are billed charges/set rates to be used in determining reimbursement for hospitals under CHAMPUS?

POLICY

1. Billed charges.

The most common method of reimbursement for covered services of hospitals is that of billed charges. The billed charge is allowable if it is reasonable and is not greater than (1) the charge made to the general public; or (2) the allowed charge applicable to FI policyholders (subscribers), where extended to CHAMPUS beneficiaries by consent or agreement; or (3) the charge set by local or state regulatory authority as applicable to citizens and extended by law or regulation, consent or agreement to CHAMPUS.

All reasonable charges of providing patient care shall be included in evaluating the reasonableness of charges and rates. Reasonable charges take into account both direct and indirect costs of hospitals. The reasonable charges will vary from one hospital to another because of scope of services, level of care, geographic location, and utilization. It is the intent of CHAMPUS to reimburse hospital rates and charges regardless of how widely they vary from hospital to hospital, provided they are reasonable, except where it comes to the attention of the FI or OCHAMPUS that a particular hospital's charges substantially exceed those of other hospitals in the same area which are similar in size, scope of service, utilization, and other relevant factors. "Utilization" includes not only the occupancy rate, but the characteristics of the patient mix (age of patients, extent of CHAMPUS eligibles, types of illness, etc.).

2. All-inclusive rates.

Some providers do not routinely itemize their charges or vary their charges depending upon the various services rendered. Instead, such

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providers have a set schedule of "all-inclusive" rates which are charged to all patients (or all patients in a given category such as surgical, medical, obstetrical, etc.) regardless of the specific services rendered to each patient. Such rates are based on a per diem or per admission amount and may consist of a single amount for all services or a basic "room and board" charge and a separate set charge for ancillary services. Such all-inclusive rates may be reimbursed so long as they are uniformly charged to all patients and so long as the hospital is incapable of itemizing its bills.

Diagnosis-related group (DRG) amounts which hospitals have elected to use in lieu of normal billed charges also qualify as all-inclusive rates. These DRG amounts may be derived from some third-party payer such as Medicare or a Blue Cross plan. CHAMPUS payments based on DRG amounts are authorized only if they are the basis for the hospital's billing--not just the basis for payment by some source.

3. Unauthorized private room charges.

An unauthorized private room is to be reimbursed at the semi-private room rate. Where the hospital has varying semi-private room rates depending on the particular medical classification, e.g., maternity, pediatric, general medical, etc., reimbursement is to be at the rate for the type of semi-private room the beneficiary would have used.

Subject: HOSPITAL REIMBURSEMENT - OTHER THAN BILLED CHARGES	Chapter: 3 Section: 6
Authority: DoD 6010.8-R, Chapter VI.E.1.b. and E.1.c.	Page: 6.2.1
Approval: Robert D Seamon for Director	Date: August 26, 1985

ISSUE

What methods other than billed charges may be used to determine hospital reimbursement under CHAMUS?

POLICY

Where discount agreements are available to the FI, the FI shall obtain such discounts for CHAMPUS reimbursement. Moreover, the FI shall determine if any state in its jurisdiction has enacted legislation which implements a ratesetting system which can be applied to CHAMPUS. If so, the FI shall utilize the rates. The FI shall maintain documentation of its actions with regard to each state which shows how any discounts or state-set rates are used or the reasons they cannot be used.

FI's may negotiate agreements with providers to extend the Medicare cost reimbursement methodology, including appropriate modifications, to cover reimbursement of CHAMPUS-covered services. Once the FI has established a feasible plan for implementing such individually negotiated provider agreements, the proposal must be submitted to the OCHAMPUS Contracting Officer for review and approval before the FI proceeds with implementation. The proposal must demonstrate lower benefit costs than available through the FI's currently approved method of reimbursement.

FI's may negotiate individual or collective agreements with providers to establish a prospective reimbursement method that demonstrates savings in CHAMPUS benefit dollars through implementation of improved cost controls. Once the FI has established a feasible plan for implementing the negotiated provider agreements, the proposal must be submitted to the OCHAMPUS Contracting Officer for review and approval before the FI proceeds with implementation. The proposal must demonstrate lower benefit costs than available through the fiscal intermediary's currently approved method of reimbursement.

Revision No: Revision Date:

Subject:
HOSPITAL REIMBURSEMENT - PAYMENT WHEN ONLY SNF LEVEL OF CARE IS REQUIRED

Chapter: 3

Section: 6

Authority:
DoD 6010.8-R, Chapter IV.B.1.g.

Page:
6.3.1

Approval: Robert D Seamon for Director

Date: August 26, 1985

ISSUE

How is a hospital to be paid for a patient who only requires SNF care?

POLICY

When it is determined that a hospital may be paid for care provided to a beneficiary who requires only SNF care, payment is to be at the SNF rate. In order to determine the payment, the fiscal intermediary is to use either the rate for the SNF which most likely would be used by the beneficiary, or it may use an average of the rates of comparable, equally accessible SNFs.

Revision No:

Revision Date:

Subject: SKILLED NURSING FACILITY (SNF) REIMBURSEMENT	Chapter: 3 Section: 7
Authority: DoD 6010.8-R, Chapter VI.E.1.	Page: 7.1.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

ISSUE

How are SNFs to be reimbursed under CHAMPUS?

POLICY

SNF reimbursement may follow any of the procedures listed in Sections 6.1. and 6.2. for hospitals.

Revision No:	Revision Date:

Subject: RESIDENTIAL TREATMENT CENTER (RTC) REIMBURSEMENT	Chapter: 3 Section: 8
Authority: DoD 6010.8-R, Chapter VI.E.2.	Page: 8.1.1
Approval: Deputy Director	Date: August 26, 1985

ISSUE

How are RTCs to be reimbursed under CHAMPUS?

BACKGROUND

A residential treatment center (RTC) is a facility or distinct part of a facility that provides, to children and adolescents, a total, twenty-four hour, therapeutically planned group living and learning situation where distinct and individualized psychotherapeutic interventions can take place. A residential treatment center is organized and professionally staffed to provide residential treatment of mental disorders to children and adolescents who have sufficient intellectual potential to respond to active treatment (that is, for whom it can reasonably be assumed that treatment of the mental disorder will result in an improved ability to function outside the residential treatment center), for whom outpatient treatment is not appropriate, and for whom a protected and structured environment is medically or psychologically necessary.

In order to become authorized CHAMPUS providers, RTCs must sign a participation agreement. The agreement, among other things, requires the RTC to accept the CHAMPUS determined rate as payment in full and collect from the CHAMPUS beneficiary or the family of the CHAMPUS beneficiary only those amounts that represent the beneficiary's liability, as defined by regulations, and charges for services and supplies that are not a benefit of CHAMPUS. This does not include charges for items not covered by CHAMPUS, e.g., education.

The OCHAMPUS responsibility for execution of the participation agreements has been delegated to the Office of Medical Affairs. All participation agreements include the specific rate established for each RTC, and the billing number that must be used for claims submission.

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POLICY

1. Rate Structure: Determination of Rate

a. The CHAMPUS rate is the per diem rate CHAMPUS will authorize for all mental health services rendered to a patient in a CHAMPUS-approved RTC, and is the lowest of one of the following:

(1) The CHAMPUS rate paid to the RTC for "all-inclusive" services as of March 1, 1985. (Used only in OCHAMPUS' initial determination of each RTC's rate); or

(2) The per diem rate accepted by the RTC from any other agency or organization (public or private) or individual that is high enough to cover one third (1/3) of the total patient days during the twelve (12) month period ending February 28, 1985; or

(3) A capped, all-inclusive per diem rate of $248.00.

NOTE: The capped per diem rate was derived from data provided by each RTC for the twelve month period ending February 28, 1985 and adjusted for 1985 by using the national consumer price index rate of increase for medical care, effective March 1, 1986, of 7.2 percent. The amount was set at the 80th percentile which is consistent with current methodology for professional services.

b. See Appendix B of this Volume Two for a listing of approved RTCs and their rates.

2. CHAMPUS rates are all-inclusive and are established based upon data provided by each RTC. Noncovered charges such as education and personal items (toiletries and clothing) are excluded. Payment can be made only to the RTC for all mental health services provided to or in behalf of the RTC patient, regardless of where provided or who provides the service. This includes all individual and group psychotherapy rendered to the RTC patient, family therapy rendered to the parents of the RTC patient (SEE 3. BELOW), whether or not the patient is physically present, collateral visits with individuals other than the RTC patient determined necessary in order to gather information or implement treatment goals for the patient, and all other ancillary services provided by the RTC. Claims submitted by the RTC for residential treatment care will be paid based upon the rate established by the participation agreement. All other mental health claims submitted by other providers for services rendered to

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* the RTC patient (except for inpatient claims as described in 3 below) will be denied. Other mental health providers may continue to render services to RTC patients under this payment system; however, such providers must look to the RTC for their payment. *

* 3. Covered nonmental health services, (e.g., treatment of broken leg,) rendered by nonmental health providers during an RTC stay can be billed by and paid to the nonmental health provider. Services requiring admittance to another type of facility, i.e., acute mental or medical hospital, would be treated as a discharge from the RTC and payment for RTC services will be denied for the same period. Mental health treatment provided by an authorized CHAMPUS provider to a parent eligible for CHAMPUS coverage in his or her own right, and which is based upon the parent's own separately diagnosed DSM III category, can be billed separately under the parent's name, even if the parent's treatment is occasioned by the RTC admission. This is true even if the parents reside at a distance from the RTC. *

* 4. For all admissions on or after July 1, 1986, the first three days of each approved therapeutic absence will be reimbursed at 100 percent of the CHAMPUS all-inclusive rate. Beginning with the fourth day of a therapeutic absence, reimbursement will be at 75 percent of the rate. *

* The fiscal intermediaries will continue to reimburse RTCs for authorized therapeutic absences for patients admitted prior to July 1, 1986, at 100 percent of billed charges until the patient is discharged or transferred, or until August 31, 1986, whichever occurs first. If the patient is still in the RTC on September 1, 1986, payment for therapeutic absences will be made at 100 percent of the CHAMPUS all-inclusive rate for the first three days of each approved therapeutic absence, and will revert to 75 percent of the established rate beginning with the fourth day of the therapeutic absence. *

* POLICY CONSIDERATIONS *

* 1. These rates will become effective July 1, 1986, for admissions occurring on or after this date, and will remain in effect for a minimum of 12 months. The fiscal intermediaries will continue to reimburse RTCs for OCHAMPUS authorized admissions occurring prior to July 1, 1986, at billed charges until the patient is discharged or transferred, or until August 31, 1986, whichever occurs first. Effective September 1, 1986, payment for all authorized RTC care will be made at the rate established by the participation agreement. *

-Continued-

2. Authorization of RTC care from the OCHAMPUS Benefit Authorization Branch will continue, including the authorization of all therapeutic absences. The fiscal intermediaries must not make payment without OCHAMPUS authorization as shown on the OCHAMPUS generated Basic Program Authorization form. RTC care is authorized under the services and supply section of this form and therapeutic absences are authorized under the special instructions section of this form. Fiscal intermediaries are to deny, without any development, therapeutic absences billed by the RTC and not specified on the OCHAMPUS authorization form.

3. Payment for RTC care will only be made by the fiscal intermediaries for claims from authorized RTCs, with specifically assigned OCHAMPUS RTC billing numbers, and with OCHAMPUS' authorization for RTC care on file.

4. The CHAMPUS RTC billing number is the RTC's nine numeric digit employee identification number (EIN) and specifically has an alpha suffix.

-For further information, see COM FI, Part II, Chapter I, Section IV.H.3.

Subject: AMBULATORY SURGICAL CENTER REIMBURSEMENT	Chapter: 3
	Section: 9
Authority: DoD 6010.8-R, Chapter VI.E.2.	Page: 9.1.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

ISSUE

How are ambulatory surgical centers to be reimbursed under CHAMPUS?

POLICY

Effective December 19, 1980, claims for ambulatory surgery submitted by authorized hospital-based or freestanding ambulatory surgical centers can be paid as billed, unless the fiscal intermediary has reason to question the amount billed. All separately billed claims for professional services rendered in an ambulatory surgical center, either hospital-based or freestanding, will be reimbursed based on the applicable allowable charge profile. (See COM-FI, Part Two, chapters 1 and 2 for other requirements.) Active duty dependent's claims for professional services rendered in ambulatory surgical centers will be paid at 100% of the allowable charge as for inpatient care, since the beneficiary's cost-share will be deducted from the institutional claim of the center.

Revision No: Revision Date:

Subject: PREFERRED PROVIDER ORGANIZATION (PPO) REIMBURSEMENT	Chapter: 3
	Section: 10
Authority: DoD 6010.8-R, Chapter 4.G.12.	Page: 10.1.1
Approval: Robert D Seaman for Director	Date: November 1, 1983

ISSUE

Can CHAMPUS payments be made for services rendered to beneficiaries by a Preferred Provider Organization (PPO)?

BACKGROUND

PPOs are a relatively new innovation in the area of alternative health care delivery systems. They are networks of hospitals and physicians which provide specific services for previously agreed upon fees to a designated group of consumers on a contractual basis through a third-party payer. The third-party payer can be either an insurance plan or, more commonly, a company which is self-insured. The PPO provides "discounts" to the contracting third-party payer which in turn provides economic incentives for the buyers of care--usually the elimination of deductibles and cost-shares.

POLICY

PPOs provide services at a discounted rate through contractual arrangements with a third-party payer. In some cases either the PPO or the beneficiary may bill CHAMPUS for the difference between the provider's normal charge and the contractually-set discount amount. CHAMPUS cannot pay even on a secondary payer basis for these amounts. The rationale for this is that the contracts which PPOs have with third-party payers normally provide that they will be paid in full by the third-party payer, taking any discounts into consideration. Since this would leave no remaining amounts as the responsibility of the beneficiary, there is no further legal obligation to pay. Without such obligation, CHAMPUS cannot pay.

CHAMPUS payments can be made on a secondary payer basis in those situations where the person submitting the claim--either the beneficiary, the individual provider, or the PPO--submits evidence of beneficiary liability beyond the amounts paid to the PPO by the primary payor. The FI must ensure in such cases that the beneficiary must pay these amounts in the absence of CHAMPUS payment and that the requirement is part of the PPO contract.

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It is important to remember that PPO providers may be authorized CHAMPUS providers in their own right and may render services to individuals who are not PPO members. In such cases, CHAMPUS may pay for services rendered to non-PPO member CHAMPUS beneficiaries. The FI must ensure, however, that double coverage through another third-party payer contracted with the PPO does not exist.

Subject: COST-SHARES AND DEDUCTIBLES	Chapter: 3 Section: 11
Authority: DoD 6010.8-R, Chapter IV, F.1.	Page: 11.1.1
Approval: Deputy Director	Date: December 16, 1985

ISSUE

Application of deductible and cost-sharing for all beneficiaries.

POLICY

A. Application of deductible and cost-sharing.

1. General. Beneficiaries are responsible for paying deductible and cost-sharing amounts for civilian medical care under CHAMPUS.

2. Deductible. A beneficiary is responsible for payment of the first fifty dollars ($50.00) of the CHAMPUS-determined allowable costs or charges for otherwise covered outpatient services or supplies provided in any one fiscal year. When outpatient services are provided to more than one beneficiary member of a family during the same fiscal year, the aggregate outpatient deductible amount paid by any two or more beneficiary members of the family who submit claims shall not exceed one hundred dollars ($100.00). The fiscal year is from October 1 through September 30 of the following year.

a. Satisfaction of Deductible by One Family Member. If only one (1) beneficiary member of a family files a claim (regardless of the number of beneficiary members actually in the family), that beneficiary is only required to satisfy a fifty dollar ($50.00) fiscal year deductible for outpatient services or supplies.

b. Insufficient Amounts for Individual or Family Deductibles. If two or more beneficiary members of a family submit claims which total less than one hundred dollars ($100.00), but no one beneficiary submits a claim(s) totaling over fifty dollars ($50.00), neither the family nor the individual deductible will have been met. No CHAMPUS benefits are payable.

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Revision No: Revision Date:

3. Cost-Sharing.

a. Outpatient Services.

(1) Active duty dependents. Dependents of active duty members of the Uniformed Services (or their sponsors) and dependents of authorized NATO members are responsible for payment of twenty percent (20%) of the CHAMPUS-determined allowable costs or charges in excess of the annual fiscal year deductible for covered outpatient services or supplies.

(2) All other beneficiaries. Retirees, dependents of retirees, dependents of deceased active duty members, dependents of deceased retirees, CHAMPVA beneficiaries, and certain former spouses are responsible for payment of twenty-five percent (25%) of the CHAMPUS-determined allowable costs or charges in excess of the annual fiscal year deductible for covered outpatient services or supplies provided.

(3) Partial Hospitalization - Alcohol Rehabilitation Services. Cost-share provisions are based upon the outpatient cost-sharing criteria in paragraphs A.3.a.(1) and (2), above. Partial hospitalization days will not be counted toward the 60-day inpatient limit on mental health services. See mental health services criteria in Section VI.K.5., Chapter 1, Part Two of the COM-FI and Chapter 1, Section 11 of this Volume Two of the Policy Manual.

b. Ambulatory Surgical Center Services. Effective December 19, 1980, CHAMPUS benefits for the dependents of active duty service members were extended for ambulatory surgery performed in an approved hospital or OCHAMPUS-approved freestanding ambulatory surgical center, based on the inpatient cost-share rate of $25. All other beneficiaries will be cost-shared on an outpatient basis.

(1) The cost-share applicable to ambulatory surgery is $25 and is not subject to the outpatient deductible. The cost-share is to be deducted from the claim of the institutional provider; i.e., the hospital or the freestanding ambulatory surgical center, and covers the services of the professional provider as well as charges for ancillary services. A nonavailability statement (NAS) is not required for ambulatory surgery.

(2) The beneficiary is responsible for the $25 cost-share for each episode of ambulatory surgery performed at least 24 hours apart.

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(3) All surgical procedures performed in a non-approved ambulatory surgical center, or in a physician's or other individual provider's office are to be cost-shared as outpatient services. A provider's office may qualify as an authorized freestanding ambulatory surgical center if it meets the standards prescribed in Part Two, Chapter 2., Provider Certification, Section III.E.3. of the COM-FI (Also see Part Two, chapter 1, sections IV.J., V.C.7.f.(2)(a), VI.C.3.b., and Chapter 4, sections II.A. and III.B. of the COM-FI for additional requirements.)

c. Inpatient Services.

(1) Active duty dependents. Dependents of active duty members of the Uniformed Services (or their sponsors) are responsible for the payment of the first $25.00 of the reasonable institutional costs or charges incurred with each covered inpatient admission to a hospital or other authorized institutional provider, or the amount the beneficiary (or sponsor) would have been charged had the inpatient care been provided in a Uniformed Service hospital, whichever is greater. The following chart gives the applicable amounts determined annually by the Secretary of Defense for each year since 1977:

YEAR	CHARGE PER DAY
Calendar Year 1977	$4.10
Calendar Year 1978 (January - September 30)	$4.40
Fiscal Year 1979	$4.65
Fiscal Year 1980	$5.00
Fiscal Year 1981	$5.50
Fiscal Year 1982	$6.30
Fiscal Year 1983 and Oct., Nov., Dec., 1983	$6.55
January 1, 1984	$6.80
January 1, 1985	$7.10
October 1, 1985	$7.30

No cost-share is applied to professional claims received for services or supplies provided in conjunction with an inpatient stay for dependents of active duty members.

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(a) Inpatient Cost-Sharing Payable With Each Separate Inpatient Admission. A separate cost-sharing amount is payable for each inpatient admission to a hospital or other authorized institution regardless of the purpose of the admission; i.e., medical, surgical, etc., regardless of the number of times the beneficiary is admitted, and regardless of whether or not the inpatient admissions are for the same or related conditions; except that successive inpatient admissions shall be deemed one (1) inpatient confinement for the purpose of computing the inpatient cost-share payable, provided not more than sixty (60) days have elapsed (from day of discharge to date of admission) between the successive admissions. Successive admissions related to an accidental injury will also be determined separately. However, all admissions related to a single maternity episode shall be considered one (1) confinement regardless of the number of days between admissions. The inpatient cost-share ($25.00 or the currently determined beneficiary cost-share per day) for an active duty dependent's maternity care will be applied to the first claim received for a hospital admission whether or not resulting in a delivery.

On subsequent claims, the cost-share shall be computed on the total aggregate inpatient hospital days for the entire maternity episode.

(b) Multiple Inpatient Admissions - Same Family. A separate beneficiary inpatient cost-sharing amount will be applied for each separate admission of each beneficiary member of the family, regardless of whether admitted at the same time or from the same cause, e.g., an auto accident.

(c) Active Duty Female Delivery in Civilian Hospital. When an active duty female delivers in a civilian hospital, for whatever reason, routine newborn charges are considered as part of the mother's "maternity episode" to be paid by the branch of service of which the mother is a member. CHAMPUS benefits become available ONLY when the infant becomes a patient in his or her own right because of complications, transfer to another facility or extension of the admission. This applies even when the facility bills separately for mother and child.

(2) All Other Beneficiaries. Retirees, dependents of retirees, dependents of deceased active duty members, dependents of deceased retirees, and CHAMPVA beneficiaries are responsible for the payment of twenty-five percent (25%) of the CHAMPUS-determined allowable costs or charges for covered inpatient services or supplies.

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c. Program for the Handicapped (PFTH). Only dependents of active duty service members are eligible for services or supplies under the PFTH.

(1) Sponsor's Cost-Share.

(a) General. The sponsor is required to pay a portion of the costs for each month in which the dependent receives benefits under the PFTH. The amount the sponsor pays is based upon the pay grade. The amount required of members in each pay grade is:

Member's Pay Grade	Share Amount
E-1 through E-5	$ 25
E-6	30
E-7 and O1	35
E-8 and O-2	40
E-9, W-1, W-2, and O-3	45
W-3, W-4, and O-4	50
O-5	65
O-6	75
O-7	100
O-8	150
O-9	200
O-10	250

(b) Two or More Handicapped Dependents. If an active duty member has two or more dependents incurring expenses under the PFTH in a given month, his or her monthly obligation shall not be greater than if he or she had but one dependent receiving benefits. Cost-sharing shall be based on the charges for the handicapped dependent who incurred the least monthly expense in that month. The service member is, however, obligated to pay at least the amount for his or her pay grade. If the cost for one dependent is less than the amount for the sponsor's pay grade, the active duty member is obligated to pay that additional amount required to meet the cost for his or her pay grade toward satisfying the bill of the second dependent. CHAMPUS will cover the reasonable expense of the second (or additional) dependent without a limit after the sponsor has met his cost-share.

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(2) CHAMPUS Cost-Share. CHAMPUS' share of the cost of any benefits provided under the PFTH cannot exceed $1,000 per month, except when there are two or more handicapped dependents in the same family. Any amount remaining after the Government's maximum share has been reached is again the responsibility of the active duty member with the exception of the difference between the billed and allowed amounts on participating claims. The $1,000 per month limit on the CHAMPUS cost-share was effective October 1, 1980. Claims for services provided prior to that date shall be paid at the $350 per month rate.

(3) Cost-sharing of Absences from an Institution. As a general rule, CHAMPUS will not cost-share any costs incurred during a period the handicapped dependent is absent from an institution with the following exceptions:

(a) Illness or Injury Requiring Hospitalization. When the handicapped dependent requires hospitalization, benefits under the PFTH may be continued up to the last day of the calendar month following the calendar month in which the hospital inpatient stay begins.

(1) For example, a beneficiary with severe mental retardation and a heart condition, in a home for the retarded, requires surgery for the heart condition. The beneficiary is admitted to the hospital on April 20 and returns to the home on May 31. Payment may be made to the home for the period April 21 through May 31. If the beneficiary does not return to the home until June 26, no payment can be made for the period between June 1 and June 25, inclusive.

(b) Emergency Situations. Benefits under the PFTH may be continued in bona fide emergency situations, such as serious illness or death in the immediate family, but in no case longer than seven (7) days, including travel time.

(c) Therapeutic Absences. When a handicapped dependent leaves an institution for a therapeutic absence, benefits under the PFTH may be continued for a period not to exceed seventy-two (72) hours, including travel time.

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(d) Holiday or School Vacation. When a handicapped dependent leaves an institution for a recognized holiday or school vacation during the school term, benefits under the Program for the Handicapped are limited to not more than seven (7) days each, including travel time, except that one such absence of up to fifteen (15) days, including travel time, is authorized each year. Payments for holiday and vacation absences are authorized only when all paying patients in the facility are charged for the absence.

(e) Recording of Absences. All absences must be noted on the claim form with the duration and reason. Failure to do so will result in termination of benefits.

Subject: COST-SHARES AND DEDUCTIBLES - FORMER SPOUSES	Chapter: 3 Section: 11
Authority: DoD 6010.8-R, Chapter IV.F.4.	Page: 11.1.1
Approval: Robert D Seeman for Director	Date: April 19, 1983

ISSUE

What are the deductible and cost-sharing requirements for former spouses eligible for CHAMPUS? (See Chapter 1, Section 1, Page 1.1.1. of Volume II for the eligibility requirements.)

BACKGROUND

An eligible former spouse is responsible for payment of the first fifty dollars ($50.00) of the CHAMPUS-determined reasonable costs/charges for otherwise covered outpatient services and/or supplies provided in any one fiscal year. Although the law defines former spouses as dependents of the member or former member, there is no legal familial relationship between the former spouse and the member or former member. Moreover, any CHAMPUS-eligible children of the former spouse will be included in the member's or former member's family deductible. Therefore, the former spouse cannot contribute to, nor benefit from, any family deductible of the member or former member to whom the former spouse was married or of that of any CHAMPUS-eligible children. In other words, a former spouse must independently meet the $50 deductible each fiscal year.

An eligible former spouse is responsible for payment of 25% of the CHAMPUS-determined reasonable costs/charges for otherwise covered services and/or supplies provided on either an inpatient or outpatient basis by authorized providers. For outpatient services/supplies, the cost share will apply only to the reasonable costs/charges in excess of the annual fiscal year deductible amount.

Subject: COST-SHARES AND DEDUCTIBLES - FORMER SPOUSES	Chapter: 3 Section: 11
Authority: DoD 6010.8-R, Chapter IV.F.4. *	Page: 11.2.1 *
Approval: Deputy Director	Date: April 19, 1983

ISSUE

What are the deductible and cost-sharing requirements for former spouses eligible for CHAMPUS? (See Chapter 1, Section 1, Page 1.1.1. of Volume II for the eligibility requirements.)

BACKGROUND

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An eligible former spouse is responsible for payment of 25 percent of the CHAMPUS-determined reasonable costs/charges for otherwise covered services and/or supplies provided on either an inpatient or outpatient basis by authorized providers. For outpatient services/supplies, the cost share will apply only to the reasonable costs/charges in excess of the annual fiscal year deductible amount.

CHAMPUS POLICY MANUAL
VOLUME II

6010.47-M

Subject:
COST-SHARES AND DEDUCTIBLES - MATERNITY

Chapter: 3

Section: 11

Authority:
DoD 6010.8-R, Chapter IV.C.3.k. *

Page:
11.3.1 *

Approval: Deputy Director

Date: June 23, 1984

ISSUE

What are the special cost-sharing provisions for maternity care?

POLICY

Generally, covered services and supplies related to a maternity case shall be cost-shared on the basis of the status (or intended status) of the maternity patient at the time of delivery or other termination of the pregnancy.

Treatment of complications of pregnancy are payable on an inpatient or outpatient basis depending on the intended place of delivery.

Prescription drugs related to the maternity episode are also payable on an inpatient or outpatient basis depending on the status or intended status of the patient at the time of delivery or other termination of the pregnancy. However, prescription drugs provided on an outpatient basis which are not directly related to the maternity care, even though they are administered during the maternity episode, would be cost-shared on an outpatient basis.

Claims for pregnancy testing can be cost-shared on an outpatient basis if a nonavailability statement is not issued or required for the maternity episode. In the event an NAS is issued, such claims can be cost-shared along with other maternity services as appropriate.

Under normal circumstances no separate cost-share is to be collected for the newborn. The newborn is not considered a separate admission but is included in the mother's admission, and all charges for the newborn are to be considered part of the mother's charges. This causes no problems except in those cases where the hospital bills separately for the newborn. Where the mother is a dependent of an active duty member, and the hospital bills separately for the newborn, the FI must ensure that no separate cost-share is charged. Where the mother is other than a dependent of an active duty member, the mother's cost-share is to be calculated as 25% percent of the total

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charge. This can be done either by combining the bills and applying 25 percent to the total or by applying a 25 percent cost-share amount to each bill separately.

Where the newborn is admitted in his or her own right, because of complications or for whatever reason, cost-sharing amounts are to be collected for him or her. The cost-share is to be calculated as of the date the newborn is admitted to the hospital as a separate patient.

EXCEPTIONS

Ambulance services provided in connection with a maternity case are always cost-shared as outpatient services.

Subject: DOUBLE COVERAGE	Chapter: 3
	Section: 12
Authority: Public Law 97-377	Page: 12.1.1
Approval: Robert D Seaman for Director	Date: December 29, 1982

ISSUE

Double Coverage.

BACKGROUND

P.L. 97-377 which was signed by the President on December 21, 1982, substantially revised the CHAMPUS double coverage provisions. The law states, "None of the funds contained in this Act available for the Civilian Health and Medical Program of the Uniformed Services shall be available for the payment for any service or supply for persons enrolled in any other insurance, medical service, or health plan to the extent that the service or supply is a benefit under the other plan, except in the case of those plans administered under Title XIX of the Social Security Amendments of 1965 (79Stat.286)."

POLICY

Prior to payment of any claim for services or supplies rendered to any CHAMPUS beneficiary, regardless of eligibility status, it must be determined whether other coverage exists under any other insurance plan, medical service or health plan. If other coverage exists, CHAMPUS coverage is available only as secondary payer, and only after a claim has been filed with the other plan and a payment determination issued.

For purposes of CHAMPUS, the following definitions apply:

Insurance plan - An insurance plan is any plan or program which is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services and supplies. It includes plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled by law or as a result of employment or membership in, or association with, an organization or group.

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* Not included are those plans which, for all categories of beneficiaries, provide solely for cash payment of deductibles or cost shares * for which the enrollee is liable through some other coverage, or income maintenance programs which provide only cash payments for periods of hospitalization or disability, regardless of services required or expenses incurred.

Medical service or health plan - A medical service or health plan is any plan or program of an organized health care group, corporation or other entity for the provision of health care to an individual from plan providers, both professional and institutional. It includes plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled by law or as a result of employment or membership in, or association with, an organization or group.

Not included are certain federal government programs which are designed to provide benefits to a distinct beneficiary population and for which entitlement does not derive from either premium payment or monetary contribution.

Health care delivery systems not considered within the definition of either an insurance plan, medical service or health plan include the Veterans Administration, the Maternal and Child Health Program, the Indian Health Services, and entitlement to receive care from Uniformed Services Medical Care Facilities. These programs are designed to provide benefits to a distinct beneficiary population, and they require no premium payment or monetary contribution prior to obtaining care. (See the COM-FI(M), Part Two, Chapter 3 for procedural instructions.)

Beneficiaries may not waive benefits due from any plan which meets the above definitions. (See the COM-FI(M), Part Two, Chapter 3 for procedural instructions.)

These revised procedures will result in the following specific changes. The double coverage procedures are now identical for all classes of beneficiaries. The three tests for determining primary payer for active duty dependents have been eliminated, and fiscal intermediaries may no longer make payment before developing for double coverage on claims for active duty dependents. Moreover, the exclusionary clause provisions previously relating to retirees, etc. are no longer applicable. Lastly, CHAMPUS is secondary payer to all other plans including privately-purchased nongroup coverage and student health plans.

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The following special considerations apply to CHAMPUS double coverage procedures.

CHAMPUS and Medicare - Whenever a CHAMPUS beneficiary is also eligible for Medicare benefits (either under Part A, "Hospital Insurance," or Part B, "Supplementary Medical Insurance"), Medicare is always the primary payer.

CHAMPUS and Medicaid - Medicaid is essentially a welfare program, providing medical benefits for persons under various state welfare programs (such as Aid to Dependent Children) or who qualify by reason of being determined to be "medically indigent" based on a means test. In enacting P.L. 97-377, it was the intent of Congress that no class of CHAMPUS beneficiary should have to resort to welfare programs, and therefore, Medicaid was exempted from these double coverage provisions.

Whenever a CHAMPUS beneficiary is also eligible for Medicaid, CHAMPUS is always the primary payer. In those instances where Medicaid extends benefits on behalf of a Medicaid eligible person who is subsequently determined to be a CHAMPUS beneficiary, CHAMPUS shall reimburse the appropriate Medicaid agency for the amount CHAMPUS would have paid in the absence of Medicaid benefits. (See the COM-FI(M), Part Two, Chapter 3, Section IV.B. for further information.)

Worker's compensation - All CHAMPUS benefits are specifically excluded for any medical service and supply provided to a CHAMPUS beneficiary to treat a work-related illness or injury for which benefits are available under a worker's compensation program. The CHAMPUS beneficiary may not elect to waive worker's compensation benefits in favor of using CHAMPUS, and it is the beneficiary's responsibility to apply for worker's compensation benefits.

The agency having authority to do so (as designated under the applicable worker's compensation law) shall have final authority in the determination of whether or not an illness or injury is work-related. If a CHAMPUS beneficiary exhausts available worker's compensation benefits, CHAMPUS will assume the case and benefits for otherwise covered services and supplies may be extended.

In worker's compensation cases which involve a lengthy investigation by the applicable worker's compensation agency before a decision can be made as to whether a case is work-related, or which involve an unusual delay because the CHAMPUS beneficiary elects to appeal an adverse

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decision by the worker's compensation agency, CHAMPUS benefits may be extended for otherwise covered services and supplies when authorized by the Director, OCHAMPUS (or a designee).

Program for the Handicapped - All local resources must be considered and utilized before CHAMPUS benefits under the Program for the Handicapped may be extended. If a handicapped CHAMPUS beneficiary who is otherwise eligible for benefits under the Program for the Handicapped is eligible for other federal, state, and/or local assistance to the same extent as any other resident or citizen, CHAMPUS benefits are payable only on a secondary payer basis. The sponsor does not have the option of waiving available federal, state, and/or local assistance in favor of using CHAMPUS benefits.

See the COM-FI(M), Part Two, Chapter 3, Section IV. for additional information.

EFFECTIVE DATE

This change is effective for all claims processed on or after December 21, 1982, regardless of the actual date of service.

EXCEPTIONS

* An exception to this policy is entitlement under any plan administered under Title XIX of the Social Security Amendments of 1965 (79Stat.286), Medicaid. CHAMPUS remains first pay to Medicaid. *

* Payment should not be extended for services and supplies for which the beneficiary or sponsor has no legal obligation to pay; or for which no charge would be made if the beneficiary was not an eligible CHAMPUS beneficiary. Whenever possible, all double coverage claims should be accompanied by an explanation of benefits (EOB) from the primary insurer. If the existence of a participating agreement limiting liability of a beneficiary is evident on the EOB, payment is to be limited to that liability; however, if it is not clearly evident, the claim is to be processed as if no such agreement exists. *

CHAPTER 4

ADMINISTRATION

CHAPTER 4 - ADMINISTRATIVE POLICY

SECTION		PAGE
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2.	Nonavailability Statements (DD Form 1251) for Inpatient Care	2.1.1
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Subject: REQUIREMENTS FOR DOCUMENTATION OF TREATMENT IN MEDICAL RECORD	Chapter: 4
	Section: 1
Authority: DoD 6010.8-R, Chapter VII, G.	Page: 1.1.1
Approval: Robert D Seaman for Director	Date: July 19, 1983

ISSUE

Minimum requirements for documentation of treatment in medical records.

BACKGROUND

Recent audits have identified the problem of infrequent and sporadic entries into the medical records by billing physicians making it difficult to demonstrate ongoing personal involvement in the case. This has initiated a need for policy guidelines for documentation requirements for case management and billing under the CHAMPUS.

POLICY

An adequate medical record should give a pertinent chronological report of the patient's course in the hospital and should reflect any change in condition and the results of treatment. All significant information pertaining to a patient should be incorporated into the patient's medical record and be subject to utilization review and quality assurance established and maintained through the hospital's administration and medical staff.

* An outpatient medical record or office notes must, at a minimum, *
* list the diagnosis and document the services rendered to a patient. *

Payment should only be extended for actual services rendered and documented in the medical record. These services may be verified either through the physician's notes, nurse's notes or entries by specified professional personnel. If documentation for billed services cannot be confirmed in the medical records, payment should be denied. It is the responsibility of the medical facility to substantiate that services were provided to the patient. A consistent pattern of lack of pertinent documentation for billed services should be considered questionable and reported to the Office of Program Integrity, OCHAMPUS for investigation.

All entries in the medical records must be dated and authenticated, and a method must be established to identify the authors of the

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entries. When rubber stamp signatures are authorized, the medical * practitioner should place a signed statement in the facility's * administrative files that he or she is the one who has the stamp and is the only one who will use it. There shall be no delegation of use of such stamps to another individual. The provider must authenticate those parts of the medical records for which he or she has responsibility.

Subject: NONAVAILABILITY STATEMENTS (DD FORM 1251) FOR INPATIENT CARE	Chapter: 4 Section: 2
Authority: DoD 6010.8-R, Chapters IV, A.9. and VII, A.7. Defense Appropriation Acts for Fiscal Year 1976 and Subsequent Fiscal Years	Page: 2.1.1
Approval: Robert D Seaman for Director	Date: February 16, 1983

ISSUE

Nonavailability Statements for inpatient care.

BACKGROUND

In some geographic locations or under certain special circumstances it is necessary for a CHAMPUS beneficiary to determine whether the required medical care (primarily nonemergency, inpatient care) can be provided through a Uniformed Service hospital. If the required medical care cannot be provided, the hospital commander (or a designee) will issue a Nonavailability Statement (DD Form 1251). DoD 6010.8-R, Chapter VII.A.7.a. states, "The Assistant Secretary of Defense (Health Affairs) is responsible for promulgating rules and regulations for the issuance of Nonavailability Statements. Such rules and regulations will change depending on the current situations."

The Defense Appropriation Acts for Fiscal Year 1976 and subsequent fiscal years restrict the use of CHAMPUS funds for payment of nonemergency inpatient care if the required care is available at a Uniformed Service Medical Treatment Facility (USMTF) within a 40-mile radius of the patient's residence. The Defense Appropriation Act for Fiscal Year 1983 stated, "No funds appropriated by this Act shall be available to pay claims for nonemergency inpatient hospital care provided under the Civilian Health and Medical Program of the Uniformed Services for services available at a facility of the uniformed services within a 40-mile radius of the patient's residence: Provided, That the foregoing limitation shall not apply to payments that supplement primary coverage provided by other insurance plans or programs that pay for at least 75 per centum of the covered services." The Defense Appropriation Act for Fiscal Year 1985 has eliminated the 75% provision and does not require a Nonavailability Statement if the beneficiary has any non-CHAMPUS insurance that provides primary coverage for the cost of the medical services. (See "Double Coverage", Chapter 3, Section 2, Page 2.1.1 of the Volume Two.)

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The DoD Instruction 6015.19, "Issuance of Nonavailability Statements," effective January 1, 1985 (Enclosure 1), defines the military catchment area and restricts the issuance of Nonavailability Statements to a beneficiary only when the care required is not available from any Uniformed Services Military Treatment Facility having a catchment area that includes the beneficiary's place of residence.

POLICY

Claims for nonemergency inpatient care rendered to beneficiaries residing within military catchment areas will not be paid unless accompanied by a valid Nonavailability Statement (NAS) or in the case of electronic media claims (EMC) and UB-82 claims, there must be an indication that the NAS is being maintained "on file." A NAS certifies that the particular care was not available to the patient at the Uniformed Services hospital at the time it was sought and is valid only for the services indicated on the form. In no way does it authorize the care as benefits under CHAMPUS. The NAS rules and regulations in effect at the time the care is rendered apply in determining the applicable requirements. A NAS (DD Form 1251) is required when the CHAMPUS beneficiary resides within one of the geographic areas identified by five digit Postal Zip Code in the January 1983 Military Health Services System (MHSS) Catchment Area Directory, Volume I, U.S. Inpatient, and subsequent updated versions adopted by OCHAMPUS. (See COM-FI, Part 2, Chapter 1, Section IV.E. and Part 4, Appendix E, MHSS Catchment Area Directory, Volume I, U.S. Inpatient.)

a. Beneficiary Responsibilities. A beneficiary is responsible for determining if a Nonavailability Statement is required for his or her area of residence and for obtaining one, if required, by first seeking nonemergency inpatient care in the Uniformed Services hospital. A beneficiary cannot avoid this requirement by arranging to be away from his or her residence when the nonemergency inpatient care is obtained, e.g., staying with a relative or traveling.

b. Issuing Authority. The authority for issuing Nonavailability Statements is limited to Uniformed Services hospital commanders (or their designees).

c. Outside the United States. NASs issued by commands outside the United States are not valid for care in facilities which are located within the fifty states or in the District of Columbia. Conversely,

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DD Forms 1251 issued by Uniformed Services' hospitals in the United States are not valid outside the United States.

d. Validity. A NAS is valid for a hospital admission (including for a chronic condition) occurring within 30 days of issuance and remains valid from the date of admission until 15 days after discharge for any follow-on treatment which is directly related to the original admission.

In the case of maternity, the date of admission will be defined as the date when the patient entered into the prenatal care program with a civilian provider, and the maternity NAS shall remain valid until 42 days following termination of the pregnancy. Also, in the event that a newborn infant remains in the hospital continuously after the discharge of the mother, the mother's NAS shall be deemed valid for the infant in the same hospital for up to 15 days after the mother's discharge. Beyond this 15 day limit, a claim for nonemergency inpatient care must be accompanied by a valid NAS in the infant's name.

A NAS issued on or after October 1, 1985, will be considered valid only if submitted on the new NAS form "DD Form 1251 84 AUG" (or later editions). The old NAS form, "DD Form 1251, 1 AUG 74," (or earlier editions) will be accepted only if issued on September 30, 1985, or earlier regardless of when the claim is filed.

NOTE: A NAS shall be issued retroactively only if the care given could not have been rendered, or it would be medically inappropriate, in a Uniformed Services hospital at the time services were delivered in the civilian sector.

e. Emergency Care. Claims for emergency care do not require a NAS . Such care must meet the criteria for a medical emergency as provided in Section 7 of Chapter 1 of this Manual.

f. Other Inpatient Services Claims Related to the Original Admission. A copy of a NAS is required for any inpatient services claim (institutional, professional or ancillary service claim) related to the original admission. If a copy of a NAS is not submitted, such claims may be associated with the previously submitted inpatient hospital services claim and the required NAS. (See COM-FI, Part 2, Chapter 1, Section IV.E.1.d.).

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g. Nonavailability Statement Requirement for Retirees and Dependents of Active Duty Service Members Residing in a Catchment Area of a Uniformed Services Facility Designated as a "Dentally Underserved" Military Facility. Retirees and dependents of active duty members have the right to dental care on a "space available" basis only at the designated military facilities. A NAS for medically necessary inpatient care, in connection with covered or noncovered dental care, is required only if the beneficiary resides in a catchment area of a designated facility. (For the list of designated facilities, see COM-FI, Part 2, Figure 1-15.) Although the dental care itself may not be covered, a NAS is required for a medical condition, for example, a cardiac problem that the dental care may complicate. The beneficiary must also obtain preauthorization from the dental fiscal intermediary for the hospitalization.

h. NAS Requirements when Beneficiary has "Other Insurance". Effective for claims processed on or after October 12, 1984, if a beneficiary is enrolled in an insurance plan that provides primary coverage for the cost of their medical services, a Nonavailability Statement is not required. The conditions for applying this provision are:

(1) The "Other Insurance" plan in which the beneficiary is enrolled must be primary under the provisions of COM-FI, Part Two, Chapter 3, "Double Coverage".

(2) The "Other Insurance" must have processed the claim and information reflecting the exact amount paid must be submitted to the CHAMPUS fiscal intermediary.

(3) The "Other Insurance" Plan must be a Medical-Hospital-Surgical plan which at least covers inpatient hospitalization of beneficiaries.

* NOTE: In situations where the mother's other insurance does not cover the newborn, a NAS will not be required for the routine newborn care. If a newborn infant becomes a patient in his or her own right, normal NAS requirements are applicable. *

EFFECTIVE DATE

Effective February 1, 1983, a NAS is required for care rendered to a beneficiary (with an inpatient admission date of February 1, 1983, or after) residing within any zip code area identified in the most current MHSS Directory. For inpatient admissions which

-Continued-

occurred prior to February 1, 1983, a NAS is required only for those zip code areas previously identified to be within the 40-mile radius of a Uniformed Services Medical Treatment Facility (USMTF). These zip codes are identified with a "NO" in the most current MHSS Directory under the column designated "NEW CNA" (see COM-FI, Part 2, Figure 1-34, for example page of the Directory and Part 4, Appendix E, MHSS Catchment Area Directory, Volume I, U.S. Inpatient).

* Effective for hospital admissions occurring on or after January 1, *
1985, a NAS must accompany all claims for inpatient care under the
* Cooperative Care Program. In the case of maternity, the date of *
* admission will be defined as the date when the patient entered into *
* the prenatal care program. *

Effective for all claims processed on or after October 12, 1984, a NAS is not required if the beneficiary is enrolled in an insurance plan that provides primary coverage for the cost of their medical services.

SUMMARY OF EXCEPTIONS

a. A NAS is not required for emergency care. (Refer to paragraph e. under POLICY, above.)

b. CHAMPVA beneficiaries are not subject to the NAS requirements, since they do not have access to care in USMTFs except in an emergency.

c. Effective October 1, 1976, a NAS is no longer required for psychotherapy provided by marriage and family counselors on an outpatient basis.

d. A NAS is not required for ambulatory surgery for dependents of active duty members and NATO members even though a claim for this service is cost shared under the inpatient cost sharing provisions.

e. Inpatient services provided in specialized treatment facilities skilled nursing facilities, student infirmaries, residential treatment centers, and inpatient care under the Program for the Handicapped are not subject to the requirement for a NAS.

f. A NAS is not required for claims under the Joint Health Benefits Delivery Program.

Department of Defense
INSTRUCTION

NUMBER 6015.19

SUBJECT: Issuance of Nonavailability Statements

References:
(a) Title 10, United States Code, Sections 1080 and 1086
(b) DoD 6010.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)" January 10, 1977
(c) DoD Instruction 6015.19, "Issuance of Nonavailability Statements," June 15, 1983 (hereby canceled)
(d) Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)) Memorandum, "Implementation of Department of Defense Instruction (DoDI) 6015.19, June 15, 1983, 'Issuance of Nonavailability Statement'; Additional Guidance", June 8, 1984 (hereby canceled)
(e) through (i) see enclosure 1

A. REISSUANCE AND PURPOSE

Under the authority of reference (a) and the further delineation of this authority in reference (b), this Instruction consolidates DoD policy governing the issuance of DD Form 1251, nonavailability statements (NAS), assigns responsibility for implementation, specifies mechanisms and procedures for issuing NASs, revises DD Form 1251 (enclosure 2), modifies the Nonavailability Statement Report (enclosure 3) adds the OASD(HA) Data Management Information System (DMIS) facility codes (enclosure 4). This Instruction hereby consolidates, reissues, and cancels references (c) and (d).

B. APPLICABILITY AND SCOPE

1. The provisions of this Instruction apply to the Office of the Secretary of Defense, the Military Departments, and by agreement with the Coast Guard, the other Uniformed Services and organizations operating former Public Health Service (PHS) facilities.

2. Its provisions apply only to nonemergency inpatient care provided at civilian facilities to Uniformed Services Health Benefit Program beneficiaries who reside within the inpatient catchment areas of a Uniformed Service medical treatment facility (USMTF).

C. DEFINITIONS

1. Catchment Area. As used in this document, a catchment area refers to the geographic area surrounding each USMTF or former PHS facility, which constitutes the inpatient service area for the facility. Inpatient catchment areas in the United States are defined by zip codes and are based on an area of approximately 40 miles in radius surrounding each inpatient facility. The

zip codes designating a catchment area in the United States are specified in Volume I of the Military Health Services System (MHSS) Catchment Area Directory. The catchment areas for facilities outside the United States are defined by postal codes, town names or devices specified on maps provided to the ASD(HA) or his designee by the Secretaries of the Military Departments.

2. Former PHS Facilities. Former PHS facilities are facilities that were operated by PHS, are presently operated by civilian organizations, and are deemed under Public Law 97-99 (reference (e)) to be USMTFs.

3. Medically Inappropriate. This situation arises when denial of an NAS could result in significant risk to the health of the patient or significant limitation to the patient's reasonable access to needed health care.

4. Military Departments. The term "Military Departments" as used in this Instruction, refers to the Army, the Navy, including the Marine Corps, and the Air Force.

5. Other Uniformed Services. The term "other Uniformed Services" as used in this document refers only to the Commissioned Corps of the PHS and the National Oceanic and Atmospheric Administration. The Coast Guard is specified by name.

6. Uniformed Services Medical Treatment Facilities. USMTFs are medical facilities that are operated by one of the Military Departments or the Coast Guard and, for the purposes of this document, except where marked by an asterisk (*), USMTFs also refer to former PHS facilities.

7. United States. The term "United States" as used in this document refers to the Continental United States (CONUS), Alaska, and Hawaii.

8. Valid NAS. The term "valid NAS" as used in this document refers to an NAS that is used within the time specified in the Instruction. It does not mean that the NAS guarantees CHAMPUS coverage.

D. POLICY

It is DoD policy that:

1. A USMTF shall issue an NAS to a beneficiary only when the care required is not available from any USMTF having a catchment area that includes the beneficiary's place of residence.

2. CHAMPUS shall share the cost of nonemergency inpatient care rendered to beneficiaries residing within a USMTF catchment area only when the beneficiaries are enrolled (with the exceptions specified in reference f) in the Defense Enrollment Eligibility Reporting System (DEERS) and possess a valid NAS or when beneficiaries have any non-CHAMPUS insurance that provides primary coverage for the cost of their medical services.

3. The issuance of an NAS shall not guarantee that CHAMPUS will share the cost of the care specified on the NAS.

E. RESPONSIBILITIES

1. The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) shall ensure that copies of the MHSS Catchment Area Directory shall be furnished to the following:

a. The Secretaries of the Military Departments and the Commandant of the Coast Guard for use by the USMTFs.

b. The Director, Office of CHAMPUS (OCHAMPUS), for use by the CHAMPUS fiscal intermediaries.

c. The Surgeon General of the PHS to share with NOAA.

d. The Directors of former PHS facilities.

2. The Secretaries of the Military Departments, the Commandant of the Coast Guard, and the Directors of the former PHS facilities shall:

a. Establish procedures to control the issuance of NASs, including an appeal process.

b. Establish and maintain a system of data collection on the number of NASs issued by each facility according to reason for issuance, specialty of care, and category of beneficiary. These data shall be reported quarterly by electronic media to the ASD(HA) within 60 days of the end of each quarter using formats specified in enclosure 3.

c. Provide the ASD(HA) with zip codes (where appropriate) and maps defining the catchment areas of USMTFs outside the United States within 120 days of the issuance of this Instruction and update them as necessary.

d. Retain copies of the issued Forms 1251 for not less than 24 months to be available for audit, as may be required.

3. The Director, OCHAMPUS, shall:

a. Ensure that claims for nonemergency inpatient care rendered to beneficiaries living within a catchment area will not be paid unless the claims meet the criteria enumerated in this Instruction.

b. Provide the Secretaries of the Military Departments with required formats for maps of catchment areas outside the United States.

F. PROCEDURES

1. Care shall be considered not available only in the following circumstances:

a. Proper facilities are not available.

b. Professional capability is not available.

c. It would be medically inappropriate to require the beneficiary to use the USMTF. In determining when it is medically inappropriate to require beneficiaries to use the USMTF, local commanders will assess individual medical needs and personal constraints upon an individual's ability to get to the USMTF. In making a judgment on medical appropriateness, local commanders will use their discretionary authority to determine when obtaining care from a specific civilian source rather than a USMTF would be essential to enable the beneficiary to receive needed health care in a safe and timely manner.

2. When the residence of the beneficiary is within the catchment area of two or more USMTFs with inpatient capability, the first facility contacted shall be responsible for providing the requested care, for contacting other USMTFs to see if care is available or for issuing an NAS if care cannot be provided at any of the USMTFs whose catchment areas contain the zip code of the beneficiary's residence. Should the required care be available, the beneficiary shall be referred to that facility for care, and an NAS will not be issued. Each USMTF shall implement measures ensuring that an audit trail related to each check and referral is maintained.

3. Standard procedures shall be followed by all USMTFs for completing NAS DD Forms 1251 in accordance with instructions on the Form (enclosure 2). All Military Departments, the Coast Guard and former PHS facilities will use the standard format in enclosure 3 for transmitting quarterly reports to OASD(HA) by electronic media. The unique 10 digit log number assigned to each NAS will be used to identify the issuing USMTF (enclosure 4) and to calculate the NAS expiration date. The diagnostic specialty code on each NAS will limit the general category of care for which the NAS may be used.

4. An NAS shall be valid for a hospital admission occurring within 30 days of issuance and remain valid from the date of admission until 15 days after discharge for any other required treatment that is directly related to the original admission. In maternity cases the date of admission is the date when the patient entered into the prenatal care program with a civilian provider, and the maternity NAS shall remain valid for 42 days following termination of the pregnancy. If a newborn infant remains in the hospital continuously after the discharge of the mother, the mother's NAS shall be valid for the infant in the same hospital for up to 15 days after the mother's discharge. Beyond this 15 day limit, the beneficiary must request the issuing facility to make a determination on the availability of care for the infant, and issue an NAS for the infant if the requirements of this instruction are met.

5. In accordance with the general provisions of the annual DoD Appropriations Act (reference (g)), an NAS is not required for emergency care or when the beneficiary has non-CHAMPUS insurance that provides primary coverage for the cost of their medical services. Other insurance may include Medicare for those active duty dependents who have Medicare eligibility.

6. An NAS shall be issued retroactively only if the care provided by civilian sources could not have been obtained from a USMTF for reasons specified in item F.1., above, at the time services were delivered in the civilian sector. While the date of service will be recorded on the Form 1251, the NAS will be reported in the quarterly report that it was issued.

7. An NAS shall not be issued to people who are known to be ineligible for CHAMPUS or for medical services that CHAMPUS clearly does not cover (reference (b)). NOTE: Persons ineligible for CHAMPUS include dependent parents, dependent parents-in-law, secretarial designees, and retirees and their dependents who are eligible for Medicare Part A.

8. An NAS should not be issued until it has been determined that there are no other appropriate ways to arrange for health care services requested in a USMTF. Other arrangements to be considered include using the USMTF* Joint Health Benefit Delivery Program (reference (h)), having the USMTF* contracting for health care services, or, with the beneficiary's consent arranging for the beneficiary to travel to a more distant USMTF using land transportation or aeromedical transportation (reference (i)).

9. An NAS must be issued by the USMTF* in conjunction with all DD Forms 2161 that are issued for inpatient care under the Cooperative Care Program (reference (j)).

10. An NAS issued by a facility *outside* the United States will not be valid for care received in a *civilian* facility *within* the United States. Also, an NAS issued by a facility *inside* the United States will not be valid for care received in a civilian facility *outside* the United States.

G. INFORMATION REQUIREMENTS

The reporting requirements in this Instruction have been assigned Reports Control Symbol DD-HA(Q) 1463.

H. EFFECTIVE DATE AND IMPLEMENTATION

This Instruction will be effective January 1, 1985. Forward two copies of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 120 days of the effective date.

William Mayer, M.D.

William Mayer, M.D.
Assistant Secretary of Defense
(Health Affairs)

Enclosures - 4
1. References
2. Nonavailability Statement and Instructions (DD Form 1251)
3. Format Instructions for Reporting Requirements on the Nonavailability Statement (NAS)
4. DMIS Facility Codes

REFERENCES, continued

(e) Public Law 97-99, Military Construction Authorization Act, FY 1982
(f) Assistant Secretary of Defense (Health Affairs) Memorandum, "Denial of Health Benefits for Dependents not Enrolled in DEERS", August 14, 1984
(g) DoD Appropriations Act
(h) DoDI 6010.12, "Joint Health Benefits Delivery Program," January 10, 1983
(i) DoD 4515.13-R, "Air Transportation Eligibility," January 1980, Chapter 11, pages 1-4
(j) Assistant Secretary of Defense (Health Affairs) Memorandum, "Cooperative/Supplemental Care: Change to Joint Service Regulation and Medical Services Uniformed Services Health Benefit Program", May 31 1978

Enclosure 2

PRIVACY ACT STATEMENT

AUTHORITY: 44 USC 3101, 41 CFR 101 et seq and 10 USC 1066 and 1079.

PRINCIPAL PURPOSE: To evaluate eligibility for civilian health benefits authorized by 10 USC, Chapter 55, and to issue payment upon establishment of eligibility and determination that the medical care received is authorized by law. The information is subject to verification with the appropriate Uniformed Service.

ROUTINE USES: CHAMPUS and its contractors use the information to control and process medical claims for payment; for control and approval of medical treatments and interface with providers of medical care; to control and accomplish reviews of utilization; for review of claims related to possible third party liability cases and initiation of recovery actions; and for referral to Peer Review Committees or similar professional review organizations to control and review providers medical care.

DISCLOSURE: Voluntary; however failure to provide information will result in denial of, or delay in payment of, the claim.

INSTRUCTIONS FOR COMPLETING DD FORM 1251

This form can only be issued in accordance with the provisions of DoDI 6015.19, "Issuance of Nonavailability Statements," as implemented by the issuing facility's host Service. (AR 40-121, NAVMEDCOMINST 6320.3, AFR 168.9, PHS General Circular No. 6, CGCOMDTINST 6320.11b, NOAA CO. 4)

The issuing officer or designee should brief the recipient on the Instructions to the Patient on the front of this form. If the patient is not enrolled in DEERS, instruct the patient to submit required paperwork immediately.

If this NAS is being issued retroactively (after the date the patient was admitted to the hospital), the last three digits of the NAS Number, Block 1, must be between 900 and 999 and an explanation provided in Item 6, "Remarks." If this condition is not met, the CHAMPUS Fiscal Intermediary will reject the claim.

SPECIFIC BLOCK INSTRUCTIONS

1. Enter an NAS Number.
   - The first three digits are the Data Management Information System (DMIS) facility identifier.
   - The next four digits represent the date the form is issued and are the last digit of the year plus the Julian Day (For example, if the date is 1 January 1985, these digits would be 5001.)
   - The final three digits are the facility sequence number:
     - Numbers 000 through 899 may be assigned in accordance with the implementing instructions of the issuing facility's host Service.
     - Numbers 900 through 999 are assigned to NAS's issued retroactively. Enter the civilian hospital name and admission date for which the NAS applies in Item 6, "Remarks."

2. Check the appropriate box. If "Medically Inappropriate" is checked, specify why in Item 6, "Remarks," and ONLY if the reason relates to access, indicate in the following order: (a) the special circumstances, (b) the name and location of the civilian source of care selected by the beneficiary, and (c) the approximate distance from the source of care to the USMTF.

3. **Enter the code for the type of problem for which the NAS is being issued from the following list.** For further information on what goes into each category, consult the "User's Guide for the CHAMPUS Cost and Workload Report" in the Service's implementing instructions.

01-Adverse Reactions
02-Allergy
03-Cardiology
(Vascular Disease)
04-Dermatology
05-Endocrinology
06-Gastroenterology
07-Hematology
08-Infectious Disease
09-Nephrology
10-Neurology
11-Nutritional
12-Pulmonary/Respiratory
13-Rheumatology
14-Internal Medicine, General
(not specified above)
15-Dental
16-Obstetrics
17-Gynecology
18-Ophthalmology
19-Psychiatry (GP I)
20-Psychiatry (GP II)
21-Special Pediatrics
(Congenital Anomolies, Neonatology)
22-Ear, Nose, Throat
23-General Surgery
24-Neurosurgery
25-Orthopedics
26-Thoracic Surgery
27-Urology

4a. Enter the PATIENT'S name.

4b. Enter the PATIENT'S home address. You must include the ZIP Code.

4c. Enter the PATIENT'S date of birth. Enter two digits each for year, month, day with no dividers. January 23, 1985 will be entered as 850123.

4d. Enter the PATIENT'S sex.

4e. Mark the appropriate box.

4f. Mark the appropriate box. If "f(2), Yes," is marked, specify the name of the insurance company and the policy number, if available, in Item 6, "Remarks."

5a. Enter the SPONSOR'S name. If the sponsor is the patient, enter "SAME."

5b. Enter the SPONSOR or RETIREE's Social Security Number.

6. Enter remarks as required by these instructions and implementing instructions.

7a, c and d. Type or print the name, pay grade, and title of the individual issuing this NAS.

7b. The Issuing Officer must sign the form.

7e. Enter the date the form is issued. This date should be the same day of the year as the Julian date in block 1; however, it should be spelled out (i.e., 1985 January 23) so the patient knows exactly when the form was issued. The form should be signed by the issuing officer and given/sent to the beneficiary on the date of issuance.

UNIFORMED SERVICES MEDICAL TREATMENT FACILITY NONAVAILABILITY STATEMENT (NAS)

(See Privacy Act Statement on Reverse)

INSTRUCTIONS TO THE PATIENT

Concerning use by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

1. The medical care requested is not available to you at a Uniformed Services medical treatment facility in this area.

2. This form does NOT guarantee that CHAMPUS will cost share your care.

a. If you receive medical care from civilian sources and such care is determined to be authorized care under CHAMPUS, it will be cost shared by the Government to the extent that the program permits, provided such care is not obtained in an inpatient facility which discriminates in its admission and treatment practices on the basis of race, color, or national origin.

b. If you receive medical care from civilian sources and it is determined that all or part of the care is not authorized under CHAMPUS, the GOVERNMENT WILL NOT PAY for the unauthorized care.

c. The determination of whether medical care you receive from civilian sources is covered under CHAMPUS can not be made at this time because this determination depends, among other things, upon the care you actually receive and not upon the statement regarding your condition or diagnosis made on this form.

3. This form must be presented with your Uniformed Services Identification and Privilege Card when you obtain civilian medical care. For your claim to be processed, you must be enrolled in the Defense Enrollment Eligibility Reporting System (DEERS).

4. This form is valid only for medical care requested from and determined not available at a Uniformed Services medical treatment facility in this area.

5. This Nonavailability Statement is valid for a hospital admission occurring within 30 days of issuance and remains valid from the date of admission until 15 days after discharge for any follow-on treatment that is related directly to the original admission.

a. In the case of maternity, the date of admission is defined as the date when the patient entered into the prenatal care program with a civilian provider, and the maternity NAS shall remain valid until 42 days following termination of the pregnancy.

b. In the event that a newborn infant remains in the hospital continuously after the discharge of the mother, the mother's NAS shall be deemed valid for the infant in the same hospital for up to 15 days after the mother's discharge. If the infant is likely to remain in the hospital beyond this 15 day limit, you will have to obtain a new NAS for the infant. Such an NAS will be issued by the facility only if the required care is not available in a Uniformed Services medical treatment facility in your area.

c. If you do not use this form within 30 days, or if you have questions about the expiration of the form, you should check with your local Health Benefits Advisor (HBA) prior to your admission to the hospital.

d. If you do not use this form, return it to the issuing Uniformed Services medical treatment facility.

6. If you have further questions regarding this form or your CHAMPUS benefits, you should talk with your local Health Benefits Advisor, the CHAMPUS Fiscal Intermediary for your area, or the Beneficiary and Provider Relations Division, Office of CHAMPUS, Aurora, Colorado.

I HAVE REVIEWED AND UNDERSTAND THE ABOVE INSTRUCTIONS

PATIENT'S SIGNATURE

1. NAS NUMBER (Facility) ☐☐☐ (Year - Julian Day) ☐☐☐☐ (Sequence No.) ☐☐☐

2. PRIMARY REASON FOR ISSUANCE *(X one)*
- ☐ a. FACILITIES NOT AVAILABLE
- ☐ b. PROFESSIONAL CAPABILITY NOT AVAILABLE
- ☐ c. MEDICALLY INAPPROPRIATE *(Explain in Remarks)*

3. TYPE OF PROBLEM FOR WHICH NAS IS ISSUED *(Use code from reverse)*

4. PATIENT DATA

a. PATIENT'S NAME *(Last, First, Middle Initial)*

b. ADDRESS *(Street, City, State, Zip Code)*

c. DATE OF BIRTH *(YYMMDD)*

d. SEX

e. PATIENT CATEGORY *(X One)*
- ☐ (1) DEPENDENT OF ACTIVE DUTY
- ☐ (2) RETIREE
- ☐ (3) DEPENDENT OF RETIREE
- ☐ (4) SURVIVOR
- ☐ (5) FORMER SPOUSE

f. OTHER NON CHAMPUS HEALTH INSURANCE *(X One)*
- ☐ (1) YES, BUT ONLY CHAMPUS SUPPLEMENTAL
- ☐ (2) YES *(List in Remarks)*
- ☐ (3) NO

5. SPONSOR DATA *(If you marked 4e(2) RETIREE above, write "Same" in 5a.)*

a. SPONSOR'S NAME *(Last, First, Middle Initial)*

b. SPONSOR OR RETIREE'S SOCIAL SECURITY NUMBER

6. REMARKS *(Indicate item number to which the answer applies.)*

7. ISSUING OFFICIAL DATA

a. OFFICIAL'S NAME *(Last, First, Middle Initial)*

b. OFFICIAL'S SIGNATURE

c. TITLE

d. PAY GRADE

e. DATE ISSUED *(Year, Month, Day)*

FORMAT AND INSTRUCTIONS FOR REPORTING ON THE NONAVAILABILITY STATEMENT (NAS)

Section I - NAS REPORTING SPECIFICATIONS

1. Form. NAS reporting must be on an acceptable electronic medium. As specified in "Tape Specifications for NAS Reporting" below magnetic tape is preferred. If the submitting office wishes to use any other electronic medium, clearance for such submission must be obtained from the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)) Data Management Information System (DMIS) Program Manager.

2. Content. In the electronic format specified in Section II below, each NAS report must be identified by the date and the quarter and must contain the following information (a) by facility and (b) by the reason for issuance, which are: facility not available; professionals not available; and use of facility is medically inappropriate.

	Dependent of Active Duty	Retiree	Dependent of Retiree	Survivor	Former Spouse	TOTAL
Hospital						
Specialty:						

3. Delivery. NAS reporting tapes (or other media) must be delivered within 60 days of the end of each fiscal year's quarterly reporting period, to the OASD(HA) DMIS Program Office as specified by OASD(HA).

4. For further information, contact the DMIS Program Manager, Office of Information Systems, OASD(HA), The Pentagon, Washington, D.C. 20301-1200, commercial telephone number (202) 694-4703 or AUTOVON 224-4703.

Section II - TAPE SPECIFICATIONS FOR NAS REPORTING

9-TRACK MAGNETIC TAPE
PREFER EBCDIC,
PREFER LABLED,
1600 OR 6250 BPI

FIELD DESCRIPTION	SIZE AND TYPE	POSITION
DMISID	3N	1-3
BLANK		4
BRANCH OF FACILITY A = ARMY N = NAVY F = AIR FORCE G = COAST GUARD P = FORMER PHS HOSPITAL	1A	5
FISCAL YEAR	2N	6-7
QUARTER	1N	8

FIELD DESCRIPTION	SIZE AND TYPE	POSITION
REASON FOR ISSUANCE CODE	1A	9
T = FACILITIES NOT AVAILABLE		
U = PROFESSIONAL CAPABILITY NOT AVAILABLE		
V = MEDICALLY INAPPROPRIATE		
HOSPITAL SPECIALTY CODE	2A	10-11
01 = ADVERSE REACTIONS		
02 = ALLERGY		
03 = CARDIOLOGY (VASCULAR DISEASE)		
04 = DERMATOLOGY		
05 = ENDOCRINOLOGY		
06 = GASTROENTEROLOGY		
07 = HEMATOLOGY		
08 = INFECTIOUS DISEASE		
09 = NEPHROLOGY		
10 = NEUROLOGY		
11 = NUTRITIONAL		
12 = PULMONARY/RESPIRATORY		
13 = RHEUMATOLOGY		
14 = OTHER		
15 = DENTAL		
16 = OBSTETRICS		
17 = GYNECOLOGY		
18 = OPHTHALMOLOGY		
19 = PSYCHIATRY, GROUP I		
20 = PSYCHIATRY, GROUP II		
21 = SPECIAL PEDIATRICS (CONGENITAL ANOMALIES, NEONATOLOGY) SURGERY		
22 = EARS, NOSE, THROAT		
23 = GENERAL SURGERY		
24 = NEUROSURGERY		
25 = ORTHOPEDIC SURGERY		
26 = THORACIC SURGERY		
27 = UROLOGY		
~~28 = TOTAL~~		
NUMBER ISSUED BY BENEFICIARY CATEGORY		
DEPENDENT OF ACTIVE DUTY	3N	12-14
DEPENDENT OF RETIRED	3N	15-17
RETIRED	3N	18-20
SURVIVOR	3N	21-23
FORMER SPOUSE	3N	24-26
TOTAL	3N	27-29
NUMBER ISSUED RETROACTIVELY	1A	30-32

Enclosure 4

Office of the Assistant Secretary of Defense (Health Affairs)
Data Management Information System (DMIS) FACILITY CODES

BRANCH	MTFNAME	DMISID
ARMY	BASSETT AH FT WAINWRIGHT	005
	BEAUMONT AMC FT BLISS	108
	BLANCHFIELD AH FT CAMPBELL	060
	BLISS AH FT HUACHUCA	008
	BROOKE AMC FT SAM HOUSTON	109
	CUTLER AH FT DEVENS	070
	DARNALL AH FT HOOD	110
	DEWITT AH FT BELVOIR	123
	EISENHOWER AMC FT GORDON	047
	FITZSIMONS AMC	031
	FOX AH REDSTONE ARSENAL	001
	HAWLEY AH FT BENJAMIN HARRISON	294
	HAYS AH FT ORD	023
	IRELAND AH FT KNOX	061
	IRWIN AH FT RILEY	057
	KELLER AH US MILITARY ACAD, WEST POINT	086
	KENNER AH FT LEE	122
	KIMBROUGH AH FT MEADE	069
	LETTERMAN AMC PRESIDO, SAN FRANCISCO	022
	LYSTER AH FT RUCKER	003
	MADIGAN AMC FT LEWIS	125
	MARTIN AH FT BENNING	048
	MCDONALD AH FT EUSTIS	121
	MONCRIEF AH FT JACKSON	105
	MUNSON AH FT LEAVENWORTH	058
	NOBLE AH FT MCCLELLAN	002
	PATTERSON AH FT MONMOUTH	081
	REYNOLDS AH FT SILL	098
	TRIPLER AMC HONOLULU	052
	USA HOSP AUGSBURG, GERMANY	601
	USA HOSP BAD CANNSTATT, GERMANY	602
	USA HOSP BERLIN, GERMANY	603
	USA HOSP BREMERHAVEN, GERMANY	604
	USA HOSP BRUSSELS, BELGIUM (SHAPE)	614
	USA HOSP FRANKFURT, GERMANY	605
	USA HOSP FT CARSON	032
	USA HOSP FT POLK	064
	USA HOSP FT STEWART	049
	USA HOSP GORGAS, PANAMA	613
	USA HOSP HEIDELBERG, GERMANY	606
	USA HOSP HONSHU, JAPAN	610
	USA HOSP LANDSTUHL, GERMANY	607
	USA HOSP SEOUL, KOREA (121ST EVAC)	612
	USA HOSP VICENZA, ITALY	611

BRANCH	MTFNAME	DMISID
ARMY	USA HOSP WUERZBURG, GERMANY	609
	WALSON AH FT DIX	082
	WALTER REED AMC WASHINGTON D.C.	037
	WEED AH FT IRWIN	131
	WOMACK AH FT BRAGG	089
	WOOD AH FT LEONARD WOOD	075
AIR FORCE	E BERGQUIST HOSP OFFUTT AFB	078
	DAVID GRANT MED CEN TRAVIS AFB	014
	GRISSOM USAF HOSP GRISSOM AFB	293
	MALCOLM GROW MED CEN ANDREWS AFB	066
	KEESLER MED CEN KEESLER AFB	073
	MACDILL REG HOSP MACDILL AFB	045
	MARCH REG HOSP MARCH AFB	021
	MED CEN WRIGHT-PATTERSON AFB	095
	MINOT REG HOSP MINOT AFB	094
	SCOTT MED CEN SCOTT AFB	055
	SHAW REG HOSP SHAW AFB	101
	USAF ACADEMY HOSPITAL COLORADO	033
	USAF HOSP ALTUS AFB	097
	USAF HOSP ATHENS HELLENIKON, GREECE	631
	USAF HOSP BARKSDALE AFB	062
	USAF HOSP BEALE AFB	015
	USAF HOSP BERGSTROM AFB	115
	USAF HOSP BITBURG, GERMANY	626
	USAF HOSP BLYTHEVILLE AFB	012
	USAF HOSP CANNON AFB	085
	USAF HOSP CASTLE AFB	017
	USAF HOSP CHANUTE AFB	054
	USAF HOSP CLARK, PHILIPPINES	636
	USAF HOSP COLUMBUS AFB	074
	USAF HOSP DAVIS-MONTHAN AFB	010
	USAF HOSP DOVER AFB	036
	USAF HOSP DYESS AFB	012
	USAF HOSP EDWARDS AFB	019
	USAF HOSP ELLSWORTH AFB	106
	USAF HOSP ELMENDORF AFB	006
	USAF HOSP ENGLAND AFB	063
	USAF HOSP F E WARREN AFB	129
	USAF HOSP FAIRCHILD AFB	128
	USAF HOSP GEORGE AFB	020
	USAF HOSP GRAND FORKS AFB	093
	USAF HOSP GRIFFISS AFB	088
	USAF HOSP HAHN, GERMANY	627
	USAF HOSP HILL AFB	119
	USAF HOSP HOLLOMAN AFB	084
	USAF HOSP HOMESTEAD AFB	044

BRANCH	MTFNAME	DMISID
AIR FORCE	USAF HOSP INCIRLIK, TURKEY, (TUSLOG DET 47)	635
	USAF HOSP IRAKLION, CRETE	634
	USAF HOSP K I SAWYER AFB	072
	USAF HOSP KIRTLAND AFB	083
	USAF HOSP KUNSAN, KOREA	637
	USAF HOSP LAJES, AZORES	629
	USAF HOSP LANGLEY AFB	120
	USAF HOSP LAUGHLIN AFB	114
	USAF HOSP LITTLE ROCK AFB	013
	USAF HOSP LORING AFB	065
	USAF HOSP LUKE AFB	009
	USAF HOSP MALMSTROM AFB	077
	USAF HOSP MATHER AFB	016
	USAF HOSP MAXWELL AFB	004
	USAF HOSP MCCONNELL AFB	059
	USAF HOSP MISAWA, JAPAN	639
	USAF HOSP MOODY AFB	050
	USAF HOSP MOUNTAIN HOME AFB	053
	USAF HOSP MYRTLE BEACH AFB	102
	USAF HOSP NELLIS AFB	079
	USAF HOSP OSAN, KOREA	638
	USAF HOSP PATRICK AFB	046
	USAF HOSP PEASE AFB	080
	USAF HOSP PLATTSBURGH AFB	087
	USAF HOSP RAF LAKENHEATH, ENGLAND	633
	USAF HOSP RAF UPPER HEYFORD, ENGLAND	632
	USAF HOSP REESE AFB	111
	USAF HOSP ROBINS AFB	051
	USAF HOSP SEYMOUR JOHNSON AFB	090
	USAF HOSP TINKER AFB	096
	USAF HOSP TORREJON, SPAIN	630
	USAF HOSP TYNDALL AFB	043
	USAF HOSP VANDENBURG AFB	018
	USAF HOSP WHITEMAN AFB	076
	USAF HOSP WIESBADEN, GERMANY	628
	USAF HOSP WILLIAMS AFB	011
	USAF HOSP WURTSMITH AFB	071
	USAF HOSP YOKOTA, JAPAN	640
	USAF REG HOSP CARSWELL AFB	116
	USAF REG HOSP EGLIN AFB	042
	USAF REG HOSP SHEPPARD AFB	113
	WILFORD HALL MC LACKLAND AFB	117
NAVY	MCAGCC TWENTY-NINE PALMS	030
	NAF SIGONELLA, SICILY	624
	NARMC PENSACOLA	038
	NAS KEFLAVIK, ICELAND	623
	NAV SUB MED CEN NEW LONDON	035

Enclosure 4

BRANCH	MTFNAME	DMISID
NAVY	NAVAL HOSP BEAUFORT	104
	NAVAL HOSP CHERRY POINT	092
	NAVAL HOSP GUANTANAMO BAY, CUBA	615
	NAVAL HOSP LEMOORE	028
	NAVAL HOSP PATUXENT RIVER	068
	NAVAL HOSP ROOSEVELT ROADS, PUERTO RICO	616
	NAVAL HOSP ROTA, SPAIN	618
	NAVAL HOSP SUBIC BAY, PHILIPPINES	619
	NAVAL HOSP WHIDBEY ISLAND	127
	NAVAL HOSP BETHESDA	067
	NAVAL HOSP BRANCH HOSP ADAK	007
	NAVAL HOSP BREMERTON	126
	NAVAL HOSP CAMP LEJEUNE	091
	NAVAL HOSP CAMP PENDLETON	024
	NAVAL HOSP CHARLESTON	103
	NAVAL HOSP CORPUS CHRISTI	118
	NAVAL HOSP GREAT LAKES	056
	NAVAL HOSP GUAM	620
	NAVAL HOSP JACKSONVILLE	039
	NAVAL HOSP LONG BEACH	025
	NAVAL HOSP MEMPHIS	107
	NAVAL HOSP NAPLES, ITALY	617
	NAVAL HOSP NEWPORT	100
	NAVAL HOSP OAKLAND	027
	NAVAL HOSP OKINAWA, JAPAN	621
	NAVAL HOSP ORLANDO	040
	NAVAL HOSP PHILADELPHIA	099
	NAVAL HOSP PORTSMOUTH	124
	NAVAL HOSP SAN DIEGO	029
	NAVAL HOSP YOKOSUKA, JAPAN	622
USCG	USCG ACADEMY HOSPITAL NEW LONDON	034
	USCG HOSPITAL KODIAK	130
FORMER PHS	BAYLEY SETON HOSPITAL, NEW YORK	193
	BRIGHTON MARINE PUBLIC HEALTH CENTER, BOSTON	191
	ST. MARY'S HOSPITAL, PORT ARTHUR	197
	ST. JOHN'S HOSPITAL, NASSAU BAY	192
	ST. JOSEPH'S HOSPITAL, HOUSTON	196
	ST. MARY'S HOSPITAL, GALVESTON	195
	PACIFIC MEDICAL CENTER, SEATTLE	194
	WYMAN PARK HEALTH SYSTEMS, BALTIMORE	190

Subject: JOINT HEALTH BENEFITS DELIVERY PROGRAM	Chapter: 4 Section: 4
Authority: DoD Instruction 6010.12	Page: 4.1.1
Approval: Keith W Curtis	Date: June 7, 1983

ISSUE

Policy regarding the Joint Health Benefits Delivery Program (JHBDP).

DEFINITION

The Joint Health Benefits Delivery Program is a program that allows CHAMPUS beneficiaries to receive inpatient medical care and outpatient services by civilian health care providers in military treatment facilities (MTF's).

DISCUSSION

The purpose of a JHBDP is to integrate specific resources of both OCHAMPUS and the Military Departments by allowing beneficiaries to receive inpatient medical care and outpatient services from civilian health care providers using military facilities and resources under the provisions of CHAMPUS. This will apply only when the military treatment facility is unable to provide the needed treatment for a beneficiary.

The Military Departments will administer the program, which includes selection of military treatment facilities for implementation, education of providers, beneficiaries, and facility managers, and monitoring of the savings accrued by using the JHBDP.

* OCHAMPUS involvement is detailed in the Policy section of this Policy*
* Manual issuance and in the COM-FI, Part Two, Chapter 1, Section IV. G. *

POLICY

OCHAMPUS shall enter into contracts with civilian health care providers, selected and approved in accordance with DoD Instruction 6010.12 (Attachment 1).

-Continued-

* The Policy Division, OCHAMPUS, DoD, Aurora, Colorado 80045, will be the point of contact for all contracts received and will obtain the signature of the Director after review to determine compliance with DoD Instruction 6010.12. For renewal of contract purposes, the Contract Management Division will contact the military treatment facilities directly. A copy of the approved contract will be provided by the Contract Management Division to the fiscal intermediary having responsibility for the jurisdiction in which the provider resides. *

The Policy Division will review all proposed fee schedules for verification that no charge exceeds the prevailing charge as determined by CHAMPUS methodology for similar services in the same locality where the potential participating provider will render the care. After review and verification, the Policy Division will forward schedules to the Contract Management Division for any appropriate action.

If an overcharge occurs, the Contract Management Division will contact the military treatment facility for further negotiation with the participating provider.

Claims identified as JHBDP claims are payable under the following conditions:

a. The service was rendered at a military treatment facility which OCHAMPUS has been notified is participating in the JHBDP.

b. The service or supply is otherwise covered by CHAMPUS.

c. All documentation and billing requirements of CHAMPUS are met.

d. The civilian provider has signed the required agreements with the hospital administrator and OCHAMPUS.

Claims processing procedures for JHBDP claims are outlined in Part Two, Chapter 1, page 1-45 of the COM-FI.

EFFECTIVE DATE

The provisions of this policy are effective January 10, 1983.

January 10, 1983
NUMBER 6010.12

Department of Defense Instruction

83 FEB -8 -8 :51

ASD(HA)

SUBJECT: Joint Health Benefits Delivery Program

References: (a) Title 10, United States Code
(b) DoD Directive 6010.8, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); Administration of," January 10, 1977
(c) DoD Directive 6000.7, "Dissemination of Information on Medical Officers," July 29, 1982
(d) DoD 6010.8-R, "Implementation of Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," January 16, 1977 (as amended), authorized by DoD Directive 6010.8, January 10, 1977

A. PURPOSE

Consistent with references (a) and (b), this Instruction prescribes procedures that enable the Military Departments to make their medical treatment facilities (MTFs) available to health care beneficiaries using the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) in order to reduce CHAMPUS costs.

B. APPLICABILITY

This Instruction applies to the Office of the Secretary of Defense, the Office of CHAMPUS (OCHAMPUS), and the Military Departments.

C. POLICY

1. It is DoD policy to institute a Joint Health Benefits Delivery Program (JHBDP) to integrate specific resources of both OCHAMPUS and the Military Departments by allowing CHAMPUS beneficiaries to receive inpatient medical care and outpatient services from civilian health care providers using the resources of military MTFs under the provisions of CHAMPUS. This policy applies only when the military MTF is unable to provide the appropriate Military Department health care resources for treatment of CHAMPUS beneficiaries.

2. Under this policy:

a. The Military Departments shall ensure the maximum use of existing resources to provide the statutory range of benefits described in section 1074 of reference (a).

b. OCHAMPUS shall be the appropriate DoD activity for complementing services provided by MTFs.

c. Consideration of payment under the terms of CHAMPUS shall be appropriate for specific health care provider services not available in the MTFs.

D. RESPONSIBILITIES

1. The Secretaries of the Military Departments shall:

a. Select the MTF where the JHBDP will be implemented.

b. Educate MTF managers, beneficiaries, and interested civilian providers about the JHBDP.

c. Monitor the savings accrued by using the JHBDP.

2. The Surgeons General of the Military Departments shall have the authority, based on Military Department Secretary prior approval, to implement the JHBDP.

3. The Director, Office of the Civilian Health and Medical Program of the Uniformed Services, shall:

a. Enter into contracts and agreements with civilian health care providers, selected and approved in accordance with this Instruction and the CHAMPUS Health Care Provider Agreement (CHCPA) and Memorandum of Understanding (enclosure 1). The CHCPA shall include:

(1) A description of the OCHAMPUS mechanism for determining and updating allowable charges.

(2) A description of the OCHAMPUS benefit determination process as it relates to the coverage of physician services under the CHCPA.

(3) Terms for participation, including mandatory health care provider acceptance of the Memorandum of Understanding (attachment 1 to enclosure 1).

(4) Procedures for claims processing and reimbursement.

(5) An explanation that the extent of services provided under the terms of these agreements is limited to services performed in MTFs for CHAMPUS beneficiaries. Care beyond the acceptable CHAMPUS benefit limits for specific diagnoses is excluded from the terms of the CHCPA.

b. Review all proposed fee schedules for verification that no charge exceeds the prevailing charge as determined by CHAMPUS methodology for similar services in the same locality where the potential participating health care provider will render the care. If an overcharge occurs, OCHAMPUS shall contact the MTF for further negotiation with the participating health care provider.

c. Provide CHAMPUS contractors with implementing guidelines covering the JHBDP, including:

(1) Procedures for expeditious claims processing and payment for participating health care providers.

(2) Authority for direct telephone contact with designated individuals in selected MTFs to resolve any issues relating to claims adjudication for services covered under this Instruction.

4. The Commanders of Military Medical Treatment Facilities, after having obtained Surgeon General approval of requests to implement the JHBDP, shall contact OCHAMPUS for instructions to execute the CHCPA with any health care provider concerned. In addition, they shall:

a. Select and determine the number and qualifications of participating health care providers.

b. Manage all practice liability issues relating to the JHBDP.

c. Provide quality assurance controls through the medical staff appointment and reappointment procedure, the specific delineation of clinical privileges, periodic indepth provider reappraisal, and the stipulation that participating civilian health care providers adhere to MTF bylaws to the same extent required of Military Department health care providers. The commanders shall notify the Federation of State Medical Boards and OCHAMPUS of those practitioners leaving participation in the JHBDP who have had their clinical privileges limited, suspended, or revoked while a participant in the JHBDP (see DoD Directive 6000.7, reference (c)).

d. Ensure that services provided CHAMPUS beneficiaries in MTFs under the terms of the JHBDP are consistent with the CHAMPUS range of benefits outlined in current DoD Directives and OCHAMPUS operating policies (see DoD Directive 6010.8 and DoD 6010.8-R, references (b) and (d)).

e. Require participating health care providers to use all available MTF resources, that is, specialty consultants, ancillary services, and equipment and supplies.

f. Provide administrative support required to expedite participating health care provider reimbursement. This support includes completing CHAMPUS claims, obtaining health care provider signatures on CHAMPUS claims, certifying the services were provided, and submitting claims to designated CHAMPUS contractors.

E. EFFECTIVE DATE AND IMPLEMENTATION

This Instruction is effective immediately. Forward one copy of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 120 days.

John Beary

John F. Beary III, M.D.
Acting Assistant Secretary of Defense
(Health Affairs)

Enclosure - 1
  CHAMPUS Health Care Provider Agreement

DEPARTMENT OF DEFENSE

OFFICE OF CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE

UNIFORMED SERVICES

AURORA, COLORADO 80045

CHAMPUS HEALTH CARE PROVIDER AGREEMENT

THIS AGREEMENT, entered into as of the ___________ day of ___________, 19__, by and between ___________________________ of ___________________, hereinafter referred to as the participating health care provider, and the United States of America, hereinafter referred to as the government.

WITNESSETH:

WHEREAS, the participating health care provider entered into an agreement as of ________________________________ (attachment 1) whereby staff privileges at ________________________________, hereinafter referred to as the hospital, were conditionally granted by the government through the (enter Military Department) for (enter specialty) care of beneficiaries of the Civilian Health and Medical Program of the Uniformed Services, hereinafter referred to as CHAMPUS; and

WHEREAS, the government, through (enter Military Department) is interested in achieving optimum use of existing Health Benefits Program resources authorized under Title 10, United States Code, Chapter 55;

NOW, THEREFORE, in consideration of the aforementioned premises, the parties hereto agree as follows:

1. That the participating health care provider shall apply, have approved, and exercise staff privileges at the hospital for inpatient medical care and outpatient services that are directly related to the inpatient medical care (enter specialty) furnished to all patients who are CHAMPUS beneficiaries pursuant to the terms of the Memorandum of Understanding entered into with the government.

2. That the participating health care provider shall accept the CHAMPUS-determined allowable charge as payment in full for all CHAMPUS-authorized (enter specialty) services furnished to CHAMPUS beneficiaries pursuant to this Agreement.

3. That the participating health care provider shall bill the CHAMPUS beneficiary or sponsor only for the amount of the beneficiary's cost-share and any appropriate deductibles, if any, of the allowable charge for such services, and will neither bill nor collect from the CHAMPUS beneficiary or sponsor any amounts exceeding the CHAMPUS-determined allowable charge for the authorized services.

4. That the participating health care provider, or authorized representative, shall sign the CHAMPUS claim form as prepared by the hospital, confirming that the specific medical care itemized on the claim form was in fact rendered

to the beneficiary or patient on the dates indicated and that the health care provider agrees to the CHAMPUS participation agreement on the claim form as modified by this Agreement.

5. That for purposes of this Agreement only, the CHAMPUS-determined allowable charge shall be the fee schedule attached hereto as attachment 2, as negotiated by the parties and reviewed annually, but in no event shall such allowable charge exceed the prevailing charge, as determined by CHAMPUS methodology, for similar services in the same locality where the participating health care provider furnished the medical care. The participating health care provider shall furnish all service charge information requested by the government necessary for negotiation and review of the attached fee schedule.

6. Except as modified by this Agreement, care furnished by the participating health care provider under CHAMPUS shall be subject to DoD 6010.8-R, "Implementation of Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," January 16, 1977, as amended, and policy established by OCHAMPUS.

7. That this Agreement shall continue in effect through _______________, unless sooner terminated by mutual written agreement of the parties or as otherwise provided hereinafter.

8. That this Agreement may be terminated by the government upon documentation of suspension or revocation of clinical privileges, failure to abide by the provisions of the Agreement, abuse of its provisions or abuse or fraud committed against any agency of the government by the participating health care provider, and that pending any investigation of fraud or abuse, payments due and owing by the government under this Agreement may be suspended by the government.

IN WITNESS WHEREOF, each of the parties hereunto has executed this Agreement effective as of the day and year first above written.

UNITED STATES OF AMERICA

By_____________________
Title Director, OCHAMPUS
Aurora, Colorado 80045

PARTICIPATING HEALTH CARE PROVIDER

____
Name

____
Address

MEMORANDUM OF UNDERSTANDING BETWEEN

THE (enter medical treatment facility) AND (enter health care provider's name)

CITY OF ____________________ STATE ________________________

A. GENERAL

1. This agreement is entered into by and between ________________________, hereinafter referred to as the hospital, and ________________________________, hereinafter referred to as the participating health care provider.

2. The purpose of this agreement is to integrate specific (enter Military Department) hospital and OCHAMPUS resources to provide (enter specialty) services for CHAMPUS beneficiaries in selected (enter Military Department) hospitals.

3. The participating health care provider is licensed to practice medicine in the State of __________ and has completed application for clinical privileges at the hospital for the purpose of practicing medicine in (enter specialty). The participating health care provider agrees to all the terms and conditions of the application for clinical privileges at the hospital as well as the terms and conditions of this Memorandum of Understanding and also the attached CHAMPUS Health Care Provider Agreement.

4. The hospital is a U.S. Government health care facility within the Department of Defense operated by the U.S. (enter Military Department). The hospital is accountable to the Surgeon General of the (enter Military Department) as the equivalent of the Board of Trustees. The commander of (enter Military Department hospital) is the local representative of the Board of Trustees and is responsible for the operation of the hospital.

B. ARTICLES OF AGREEMENT

1. The Hospital shall:

a. Review past and current performance, determine qualifications, and select potential participating health care providers.

b. Comply with Utilization Review and Quality Assurance Directives and regulations of the (enter Military Department), including but not limited to:

(1) Ensuring that participating health care providers are credentialed in accordance with DoD and Military Department regulations and the hospital bylaws.

(2) Ensuring that participating health care providers adhere to (enter Military Department) hospital bylaws and DoD and Military Department regulations to the same extent and in the same manner as (enter Military Department) health care providers.

c. Provide facilities, ancillary support, diagnostic and therapeutic services, and equipment and supplies necessary for the proper care and management of patients under this agreement to the extent available and authorized for that facility.

d. Provide administrative support to participating health care providers, including:

(1) Maintenance of patient records, including transcription and copying service as may be necessary to satisfy both (enter Military Department) and private practitioner recordkeeping requirements.

(2) Maintenance of participating health care provider case, workload, and credentials files in support of credentialing processes.

(3) CHAMPUS claim preparation using the fee schedule as the submitted charge, certification, and submission, including obtaining appropriate signatures and assembling necessary medical documentation from patient records, as required.

(4) Reasonable accommodations within the hospital for such periods of time as the participating health care provider may be on after-hours call.

(5) Authorizing subsistence at hospital dining facilities at the rates prescribed for civilian guests.

e. Educate (enter Military Department) hospital staff personnel, beneficiaries, participating health care providers, and other interested civilian providers about the Joint Health Benefits Delivery Program.

f. Provide appropriate reimbursement for care rendered in the hospital to patients not eligible for CHAMPUS benefits.

g. Advise beneficiaries that CHAMPUS payment for services provided in the hospital under this agreement is contingent upon compliance with DoD 6010.8-R and current CHAMPUS operating policies.

2. The Participating Health Care Provider shall:

a. Monitor overall inpatient medical care and outpatient services that are directly related to the inpatient medical care of patients referred as a part of this agreement except that portion of care rendered by or at the direction of (enter Military Department) health care providers.

b. Oversee personal liability coverage applicable to clinical privileges granted with possible indemnification of the U.S. Government as a third-party beneficiary and provide full disclosure of all information, including but not limited to past performance as required by the credentialing process.

c. Abide by hospital bylaws and DoD and Military Department regulations with regard to Utilization Review and Quality Assurance Directives, including but not limited to inservice training, maintenance of records, utilization review, performance evaluation, release of medical information, and credentialing.

d. Abide by unique (enter Military Department) requirements concerning the nature of limited privileged communication between patient and health care provider as may be necessary for security and personnel reliability programs.

e. Use of all available (enter Military Department) resources, that is, specialty consultations, ancillary services, and equipment and supplies for the optimal care of patients under this agreement.

f. Adhere to the CHAMPUS Health Care Provider Agreement and claim submission requirements concerning allowable payment for services rendered (see attachment 2).

C. OTHER CONSIDERATIONS

1. Neither party shall assign, transfer, convey, sublet, or otherwise dispose of this agreement or the right, title, or interest therein, or the power to execute such agreement, to any other person, company, or corporation, without the other party's previous written consent.

2. In the event of illness or incapacity rendering the participating health care provider incapable of delivering services, care for patients under this agreement shall be transferred to other participating health care providers at the discretion of the commander of (enter Military Department hospital).

3. Notwithstanding the above, it is understood that the minimum term of this agreement is 1 year with the option to renew for a 1-year period based upon mutual agreement. Termination of this agreement shall be predicated upon satisfactory written notice to the other party not less than 90 days before the proposed termination date. However, the 90-day notice may be waived by mutual consent of the parties to the agreement or unilaterally for the convenience of the government.

4. It is understood that the participating health care provider shall abide by (enter Military Department) rules concerning the confidentiality of patient records, as embodied in the Privacy Act of 1974.

5. Participating health care providers shall abide by (enter Military Department) regulations concerning release of information to the public, including advance approval from the (enter Military Department) before publication of technical papers in professional and scientific journals.

6. It is understood that no care rendered pursuant to this agreement will be a part of a study, research grant, or other test without the written consent of the hospital, OCHAMPUS, and the Assistant Secretary of Defense (Health Affairs).

7. The hospital's liability for actions of its employees (hospital staff and Military Department practitioners, but excluding participating health care providers) is governed by Title 10, United States Code, Section 1089.

IN WITNESS WHEREOF, each of the parties hereunto has executed this agreement effective on this ________________ day of __________________, 19____.

UNITED STATES OF AMERICA

By ____________________

Title __________________

PARTICIPATING HEALTH CARE PROVIDER

____
Name

____
Address

EXAMPLE OF NEGOTIATED FEE SCHEDULE

MOST COMMON OB/GYN PROCEDURES

INPATIENT/OUTPATIENT

NAME ____

ADDRESS ____

____

		Enter Date and Approved Charge
	1969 California Relative Value Studies	
51840	Marshall-Marchetti-Krantz procedure (independent procedure)	$________
57240	Anterior colporrhaphy	$________
57250	Posterior colporrhaphy	$________
57260	Combined anterior and posterior colporrhaphy	$________
57500	Biopsy of excision of lesion of cervix, with or without fulguration, quadrant biopsy (independent procedure)	$________
57510	Cauterization of cervix, electro or thermal	$________
57520	Biopsy of cervix, circumferential (cone) with or without dilation and curettage, with or without Sturmdorff-type repair	$________
58120	Dilation and curettage, diagnostic and therapeutic (nonobstetrical)	$________
58250	Total hysterectomy, extended, corpus cancer, including partial vaginectomy	$________
58265	Vaginal hysterectomy with plastic repair of vagina, anterior and posterior colporrhaphy	$________
58620	Vaginal hysterectomy	$________
58300	Insertion of intrauterine device	$________
58320	Insufflation of uterus and tubes with air and CO_2	$________
58340	Injection procedure for hysterosalpingography	$________
58600	Transection of fallopian tube, unilateral or bilateral, abdominal approach	$________
58605	Postpartum, during same hospitalization (independent procedure)	$________
59000	Amniocentesis for diagnostic purposes, abdominal approach	$________

59400	Total obstetrical care, including antepartum care, vaginal delivery, and postpartum care (with or without low forceps and episiotomy)	$________
59601	Cesarean section, low cervical, including antepartum and postpartum care	$________
59681	Cesarean section with total hysterectomy, including antepartum and postpartum care	$________
59850	Therapeutic abortion by D&C, including suction curettage	$________
59860	Therapeutic abortion by introduction of hypertonic solution, transabdominal approach	$________

Approved______________________________
Date__________________________________

Isaacon/3198/CI22a

Subject: NEWBORN CHARGES	Chapter: 4
	Section: 5
Authority: DoD 6010.8-R, Chapter 4, Sections C.2.1. and C.3.k.	Page: 5.1.1
Approval:	Date: 19 JUL 1983

ISSUE

How are charges for routine newborn care to be billed?

BACKGROUND

It is CHAMPUS policy to consider routine newborn care (nursery charges, etc.) as part of a maternity episode. There is only one admission--that of the mother--and the cost of routine newborn care is a part of the mother's admission expenses. This policy is common throughout the health care industry. Thus, the cost of routine care rendered to a newborn in a hospital is usually included on the mother's bill. Moreover, newborns are not admitted to the hospital unless there are complications, and then the newborn is admitted in its own right. Since there is only one admission, CHAMPUS requires a deductible and/or cost-share only for the mother.

As a result of the above, CHAMPUS has required that routine newborn care be included on the mother's bill. This creates problems in some states which have reimbursement programs which require hospitals to bill newborn charges separately from the mother's charges.

POLICY

There is no particular advantage to be gained by requiring newborn charges to be included on the mother's bill. Therefore, where a hospital either chooses or is required to bill separately for routine newborn care, the fiscal intermediary is to accept and process the bill. No deductible or cost-share amounts are to be assessed against separate bills for routine newborn care. In each such case the fiscal intermediary should ensure that the bill is for routine services only, since the newborn may have been admitted in its own right. The fiscal intermediary should also ensure that the bill does not duplicate charges contained on the mother's bill.

EFFECTIVE DATE

This policy is effective for all claims processed on or after the date of this issuance.

Revision No:	Revision Date:

CHAMPUS POLICY MANUAL
VOLUME II

6010.47-M

Subject: NURSERY CHARGES:INFANT OF AN UNMARRIED DEPENDENT	Chapter: 4
	Section 5
Authority: DoD 6010.8-R, Chapter III.B.2.c.	Page: 5.2.1
Approval: Deputy Director	Date: January 23, 1984

ISSUE

Nursery charges for an infant of an unmarried dependent

POLICY

Routine nursery charges are covered as long as mother and child are both hospitalized as part of the maternity episode.

POLICY CONSIDERATIONS

If the mother is discharged before the infant, or any time the infant becomes a patient in his or her own right, the infant's care is not covered because a child of an unmarried dependent is not a CHAMPUS beneficiary.

Revision No: Revision Date:

Subject: VETERANS ADMINISTRATION FIELD TEST	Chapter: 4 Section: 6
Authority: Public Law 97-72	Page: 6.1.1.
Approval: for Maurice [illegible], Executive Officer Deputy Director	Date: 19 JULY 1983

ISSUE

Administrative assistance and support of Veterans Administration (CHAMPVA) field test.

BACKGROUND

On November 2, 1973 the Veterans Administration entered into an agreement with the Department of Defense to provide medical services and supplies to eligible dependents and survivors of veterans under the Civilian Health and Medical Program of the Veterans Administration (CHAMPVA). Under this agreement the processing of CHAMPVA claims for payment or reimbursement for cost of care is under the overall jurisdiction of the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), while the Veterans Administration retains sole responsibility for determining eligibility for this program.

DISCUSSION

Recent legislation changes in the Veterans' Health Care, Training, and Small Business Loan Act of 1981 (P.L. 97-72), November 3, 1981, have expanded the authority of the Veterans Administration to provide care and treatment to CHAMPVA beneficiaries in VA medical facilities. Because of these changes, the Veterans Administration has decided to initiate a field test to determine the feasibility of providing care to CHAMPVA beneficiaries in either VA facilities or through VA's fee basis/or contract hospitalization programs. This test was scheduled to begin on March 1, 1983. It will affect a projected 34,000 CHAMPVA beneficiaries residing in VA Medical District 23. This medical district consists of eight medical centers located in the following locations: Omaha, Nebraska; Grand Island, Nebraska; Lincoln, Nebraska; Ft. Meade, South Dakota; Hot Springs, South Dakota; Des Moines, Iowa; Iowa City, Iowa; and Knoxville, Iowa.

-Continued-

The VA has provided OCHAMPUS with an updated register of CHAMPVA beneficiaries residing in each of the test locations. The claims history of each of these beneficiaries will be flagged and claims for care rendered on or after March 1, 1983 will be forwarded to the appropriate Veterans Administration clinic along with the status of the outpatient deductibles. The Veterans Administration will notify each of the test participants of the action taken on their claims and provide the address of the medical center to which their claims should be forwarded for services received on or after March 1, 1983.

POLICY

CHAMPUS Fiscal Intermediaries will continue to process CHAMPVA claims for care received prior to March 1, 1983 and for CHAMPVA beneficiaries not on the registry. CHAMPVA claims from test participants for care received subsequent to March 1, 1983, will be referred to the appropriate VA clinic for adjudication and payment. Claims for services extending over the March 1, 1983, deadline should be split, with CHAMPUS processing that portion of care received prior to March 1, 1983, and the VA processing that portion received on or after March 1, 1983. The VA will be responsible for appeal rights over claims they are adjudicating.

EFFECTIVE DATE

* The test period will begin March 1, 1983. Test results will be * analyzed upon completion of the test and a program decision made about expanding the test.

Subject: Processing of Foreign Claims	Chapter: 4
	Section: 7
Authority: DoD 6010.8-R, Chapter I, B.1.	Page: 7.1.1.
Approval: Deputy Director	Date: 22 Oct 84

ISSUE

Requirements for processing of foreign claims.

BACKGROUND

The rigid application of requirements for processing of foreign claims has brought about administrative and public relations problems. Language barriers, along with variations in standards of practice, have made it difficult to obtain detailed information concerning both institutional and professional claims. This has ultimately resulted in excessive delays in payment of claims and alienation of foreign providers. The mobility of military personnel has often made it impossible for them to personally obtain the required supplementary information necessary for payment of their dependents' claims.

CHAMPUS Regulation 6010.8-R, Chapter I, B.1. allows exceptions to provisions of the Regulation in foreign countries if granted in writing by the Director, OCHAMPUS (or a designee). The foreword to CHAMPUS Operations Manual-Fiscal Intermediary (COM-FI) further stipulates that the rigid requirements of itemization of services and U.S. standards of practice are not required for processing of foreign claims.

POLICY

1. Itemization of Claims:

Claims for services received in foreign countries may be accepted, reviewed and processed to payment without itemization if the following minimal requirements are met.

a. The diagnosis must be identified on each claim. This information may be obtained from an approved CHAMPUS claim form or attached billing documentation (i.e., bills, receipts, or statements). The identification of individual procedures will only be requested if the total charges are out of line or if any one or more line items appear unusually high.

-Continued-

Revision:	Revision Date:

b. The services and supplies must otherwise fall within the range of CHAMPUS benefits.

c. The diagnosis or description of illness supports the reasonableness of the procedures and is commonly accepted practice in the host country or region.

Where a provider does not furnish a detailed item-by-item breakdown of services, the total submitted charge will be compared to the diagnosis and a judgement will then be made concerning the appropriateness of the billed amount. Hospital room rates are not required for processing of institutional claims.

2. Prescription Drugs and Medicines

Foreign drug claims are not subject to the rigid informational requirements set forth in the Regulation and COM-FI. However, there must be sufficient information to detect over-utilization or irrational prescribing of drugs. Utilization control and quality assurance procedures are essential for identifying possible drug abuse situations.

The Red Book is to be used as a reference source for the processing and payment of foreign drug claims. If the drug is identified as a non-prescription (over the counter) drug it is to be denied for payment. If it is listed as a prescription drug or not listed at all, payment is authorized. Food and Drug Administration (FDA) approval is not required for payment of prescription drugs and durable medical equipment (DME); however, they must be medically necessary for treatment of the condition for which they are administered and be in keeping with local medical standards of practice in the foreign country in which the care is provided. Foreign drug and DME claims are still subject to all other applicable limitations and exclusions specified in the Regulation, COM-FI and this manual. (See Policy Manual, Volume 1, Chapter 7, Section 7.).

3. Provider Certification

CHAMPUS Regulation 6010.8-R, Chapter VI, A.2., stipulates that the Director, OCHAMPUS (or a designee), may after review of the facts provide payment to, or on behalf of, a beneficiary who receives otherwise covered services or supplies from a foreign provider that does not meet CHAMPUS certification standards. Language barriers, variations in standards of practice, uncooperative foreign governments and medical societies make it extremely difficult or impossible to assure comparable certification standards outside the United States. Therefore,

-Continued-

certification/licensure will only be required if the foreign provider's services are questionable.

4. Nonavailability Statement

A nonavailability statement (NAS) must be submitted with a foreign claim for nonemergency inpatient care when the CHAMPUS beneficiary resides within the catchment area (usually a 40-mile radius) of a Uniformed Services Medical Treatment Facility. The catchment areas for facilities outside the United States are defined on maps provided by the Military Departments. (Also see the CHAMPUS Operations Manual-Fiscal Intermediary, Part 2, Chapter 1, Section IV.E.)

A NAS issued by a facility outside the United States will not be valid for care received in a civilian facility within the United States. Also, a NAS issued by a facility inside the United States will not be valid for care received in a civilian facility outside the United States.

5. Coverage Limitations

Foreign claims are subject to all applicable limitations and exclusions specified in the Regulation or COM-FI. (See the COM-FI, Part 2, Chapter 1, Section IV.H and Figure 1-18).

6. Exchange Rates

CHAMPUS will pay claims based on the exchange rate in effect on the day the claim is paid. All foreign claims will be paid in local currency.

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Subject: MENTAL HEALTH TREATMENT UTILIZATION REVIEW SYSTEM	Chapter: 4 Section: 8
Authority: DoD 6010.8-R, Chapter IV.A.10	Page: 8.1.1
Approval: Deputy Director	Date: December 5, 1984

BACKGROUND

CHAMPUS has established a mental health utilization review system to insure that services provided to beneficiaries with mental disorders are medically or psychologically necessary and provided at the appropriate level of care. The fiscal intermediaries (FIs) who have contracts with OCHAMPUS are responsible for administering three levels of review. The first level review is essentially a clerical review; the second level review is conducted by medically trained FI staff members who take a more indepth look at the clinical interventions. Peer review is the third level and is conducted by one reviewer who examines the treatment rendered by providers within the same respective discipline (psychiatry, psychology, nursing, social work, or marriage and family therapy). The system allows for special reviews to be completed when requested by OCHAMPUS or the peer reviewer and also has mandatory peer review points for inpatient and outpatient mental health services.

POLICY

All claims for services related to treatment of mental disorders are subject to the CHAMPUS mental health treatment utilization review system as outlined in Appendix A of Volume Two of this Policy Manual.

Third level review for services provided by marriage, family or pastoral counselors are conducted in accordance with the procedures described in the COM-FI pertaining to medical review.

EFFECTIVE DATE

Upon direction of the Contracting Officer.

Subject: PREAUTHORIZATION	Chapter: 4
	Section: 9
Authority: DoD 6010.8-R, Chapter IV, A.11.	Page: 9.1.1
Approval: Teresa Hawkes Director	Date: December 5, 1984

ISSUE

Preauthorization or by the Director or a designee is required in order to extend benefits for certain types of care.

BACKGROUND

The benefits available under CHAMPUS for certain types of care are limited by Regulation. In other cases, the criteria that must be met in order for benefits to be paid are highly technical. In these cases, there is a high degree of risk that benefits will not be available. To minimize the risk to the beneficiary of incurring expenses that might not be covered, the Regulation requires the beneficiary to obtain preauthorization from the Director, OCHAMPUS, or a designee, before obtaining these services. Failure to obtain preauthorization in the past resulted in denial of the claim. Under the new amendment, authorization may be given after the care is received provided all other requirements for coverage are met. Under these new criteria, the FI denies the claim if there is no authorization on file and sends the claim CEOB and all supporting documentation to OCHAMPUS for consideration.

POLICY

Preauthorization is required for the following services:

1. All adjunctive dental care, except those services provided in response to a medical emergency. Only those adjunctive dental care services essential to treat the immediate medical emergency are exempted from the requirement for preauthorization. These are reviewed only by the dental FI.

2. The Director, OCHAMPUS, may require preauthorization of admissions to inpatient facilities.

-Continued-

* 3. OCHAMPUS authorization is required before benefits may be * extended for care in psychiatric residential treatment centers. At the present time, preauthorization (prior approval) of RTC admissions is not required but is available upon request. This means that the beneficiary can be admitted to the RTC and then submit paperwork to OCHAMPUS for authorization. All claims for RTC care must have either undergone preauthorization or authorization by OCHAMPUS prior to being paid.

* 4. With the exception of preauthorization of adjunctive dental * care, which the Director, OCHAMPUS, has delegated to the dental fiscal intermediary, all preauthorization and authorization is granted by OCHAMPUS.

* 5. If a claim for services requiring authorization or preauthorization is submitted to a fiscal intermediary and there is no OCHAMPUS authorization on file (only applies to claims for services identified in paragraph 2.a.-i. and paragraph 4 above), the fiscal intermediary shall deny the claim and forward it, with all attachments to the Benefit Authorization Branch, OCHAMPUS. The claimant should be advised that the claim has been transmitted to OCHAMPUS. (Exception: The dental fiscal intermediary is delegated authority to waive the requirement for preauthorization if the claim would have been otherwise payable.)

* 6. The Benefit Authorization Branch shall review the claim to * determine if all requirements for coverage, other than the requirement for preauthorization, are met. If all requirements for coverage other than the requirement for preauthorization are met, the Benefit Authorization Branch may waive the requirement for preauthorization and return the claim to the appropriate fiscal intermediary with instructions to process the claim.

* 7. Such claims remain subject to all other program requirements. *

EFFECTIVE DATE

November 13, 1984

-Continued-

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6010.47-M

Subject: FINAL DECISIONS	Chapter: 4 Section: 10
Authority: DoD 6010.8-R, Chapter X	Page: 10.1.1
Approval: DEPUTY DIRECTOR	Date: JUN 3 1985

BACKGROUND

The CHAMPUS appeal and hearing process was established to resolve disagreements over benefit decisions. To provide beneficiaries and other proper parties to a decision the opportunity to have that consideration, a multi-tiered appeal process has been established.

1. Reconsideration. The reconsideration is the first tier in the appeal process and is an FI review designed to determine whether the initial determination was made in accordance with law, regulation, policies and guidelines in effect at the time the care was provided or requested, or at the time the provider requested approval under CHAMPUS as an authorized provider.

2. Formal Review. The formal review is the second tier in the appeal process and is an OCHAMPUS review to determine whether the initial determination and reconsideration reviews were made in accordance with law, regulation, policies and guidelines.

3. Hearing. The hearing is the third tier in the appeal process and is a nonadversary, administrative proceeding to determine the facts of the case and to allow the appealing party the opportunity to personally present the case before an impartial hearing officer.

POLICY

Final Decisions

The hearing officer makes a recommended decision which is referred to the Director, OCHAMPUS, for review. The Director, OCHAMPUS, or a designee, will adopt or reject the recommended decision as the final agency decision in the appeal or refer the recommended decision to the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) for review. The ASD(HA), after reviewing the case, may issue a final decision or remand the case to the Director, OCHAMPUS, or a designee, for appropriate action. A final decision issued by the Director, OCHAMPUS, or a designee, may not be relied on, used, or cited as precedent in the administration of CHAMPUS; whereas, a final decision issued by the ASD(HA) may be relied on, used, or cited as precedent in the administration of CHAMPUS.

EFFECTIVE DATE March 1, 1985

Revision: Revision Date:

APPENDIX

CHAMPUS POLICY MANUAL

VOLUME TWO

APPENDIX A

UTILIZATION REVIEW OF MENTAL HEALTH SERVICES

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UTILIZATION REVIEW OF MENTAL HEALTH SERVICES

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CHAPTER 1 - ADMINISTRATION

I. BACKGROUND

The CHAMPUS mental health peer review system was established to ensure that services rendered to beneficiaries with mental disorders are medically or psychologically necessary and provided at the appropriate level of care.

The fiscal intermediaries who have contracts with OCHAMPUS are responsible for administering three levels of review. Summaries of the levels of review are provided below.

II. FIRST LEVEL REVIEW

Claims submitted for services related to treatment of mental disorders enter a first level clerical review. This function is performed by:

A. Denying claims which do not conform to CHAMPUS Regulation DoD 6010.8-R, and supplementing policies when:

1. Mental health services are not provided by a CHAMPUS-authorized provider;

2. The diagnosis is not a specific nervous or mental condition referenced in the DSM-III; or,

3. The diagnosis, treatment modality or treatment setting is excluded by CHAMPUS Regulation DoD 6010.8-R.

B. Referring cases to second level review when:

1. The session length or frequency of inpatient or outpatient psychotherapy or the cumulative length of inpatient care exceeds CHAMPUS Regulations and policies (and authorization has not been granted);

2. The diagnosis, treatment intervention or treatment setting requires further consideration (as specified in this manual); or

3. Treatment has reached a mandatory or special review interval (See Section V, this chapter - Special Reviews)

C. Paying all other claims.

First level reviewers rely on core and special criteria when deciding whether to deny, pay or refer mental health claims to second level reviewers (See Chapter 2, Section 2 "First Level Review").

III. Second Level Review

Second level review is conducted by senior level, medically-trained staff who, by virtue of their education (and experience), are capable of taking a more in-depth look at clinical interventions. (Note: Second level reviewers solicit treatment reports from providers to support review activities.)

FIs may delegate certain clerical tasks associated with second level reviews to first level reviewers. However, only second level reviewers are to conduct reviews of professional services for benefit decisions.

IV. Peer Review/Third Level Review.

Peer review is the evaluation of the medical or psychological necessity, appropriateness, effectiveness, and efficiency of services rendered or ordered by practicing medical, allied or extramedical providers. The FI assigns one peer reviewer to examine the treatment rendered by providers within the same respective discipline (i.e., psychiatry, psychology, nursing, social work.) Furthermore, the peer reviewer should also share the provider's area of specialization (i.e., adult, child/adolescent, group, family or couples therapy, testing and assessment, or psychoanalysis). Areas of specialization are listed in the FI's Roster of Peer Reviewers.

The peer reviewer forms observations and recommendations based upon professional standards, norms and personal professional judgement. Since peer reviewers are carefully selected according to their credentials and experience, it is assumed that they can identify acceptable care and make valid and reliable assessments.

NOTE: Claims from marriage, family or pastoral counselers are reviewed at the third level by FI designated consultants using the criteria contained in this manual. Whenever the manual states to refer the case to peer review, the fiscal intermediary will refer it to their 3rd level review (see COM-FI, Part 2, Chapter 2, paragraph IV.K.4.c.). All other policies and guidelines are applicable.

V. Special Reviews (Third Level)

Both inpatient and outpatient care may be subject to additional retrospective review activity (special reviews) if requested by OCHAMPUS, or peer reviewers. For example, peer review may recommend that a case be formally re-reviewed prior to the next established peer review interval.

VI. Summary of Points of Review.

Inpatient - Goes to peer review at the 30th day. Benefit ends at 60th day unless a waiver is granted by OCHAMPUS.

Outpatient - Review alternates every 24 sessions between 2nd level and peer review.

Peer Review	Second Level
24th session	48th session
72nd session	96th session

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APPENDIX A

UTILIZATION REVIEW OF MENTAL HEALTH SERVICES

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CHAPTER 2 - OPERATIONS

I. AUTHORIZED PROVIDERS

CHAMPUS rules regarding who may be considered an authorized provider are derived from the annual Defense Appropriation Act. A summary is provided below:

A. Licensed physicians.

  1. Doctors of Medicine (M.D.).

  2. Doctors of Osteopathy (D.O.).

B. Clinical Psychologists.

C. Clinical Social Workers.

D. Certified Psychiatric Nurse Specialists.

E. Marriage and Family Therapists and Pastoral Counselors.

NOTE: Currently OCHAMPUS does not have established third level reviewer (peer review) resources for marriage and family therapists or pastoral counselors. While OCHAMPUS is working toward this goal, it is the FI's responsibility to operate in accordance with policy and procedure described in this manual, and providing consultants to conduct level three review.

II. FIRST LEVEL REVIEW

A. Core Criteria

All mental health claims shall be reviewed in two stages. First, claims are screened using core criteria for both inpatient and outpatient claims. Next, first level reviewers should examine the special criteria for either inpatient or outpatient claims (depending on where the patient is receiving care).

1. Deny claims when one of the following criteria are met:

   a. Provider is not CHAMPUS authorized.

   b. Diagnosis on treatment report is not a specific nervous or mental condition referenced in the DSM-III (See American Psychiatric Association; DSM-III, Appendix D: "Historical Review, and Mental Disorders Sections of ICD-9 and ICD-9-CM", APA, 1980 for a cross-reference of the ICD-9 and DSM-III codes).

c. The primary diagnosis is one of the following:

(1) DSM-III V Codes for Conditions not attributable to a mental disorder (i.e., not medically necessary); V65.20, V62.89. V71.01, V71.02, V62.30, V62.20, v62.82 V15.81, V62.89, V61.10, V61.20, V61.80, V62.81

(2) Sexual dysfunction (DSM-III: 302.50, 302.71, 302.72, 302.73, 302.74, 302.75, 302.76, 306.51, 302.70).

(3) Obesity. Services and supplies related solely to obesity and/or weight reduction are excluded benefits.

d. Therapies or procedures provided are one of the following:

(1) Biofeedback;
(2) Environmental ecological treatments;
(3) Megavitamin or Orthomolecular Therapy;
(4) Transcendental Meditation;
(5) Rolfing;
(6) Z Therapy;
(7) EST (Erhard);
(8) Primal Therapy;
(9) Bioenergetic Therapy;
(10) Carbon Dioxide Therapy;
(11) Guided Imagery;
(12) Sedative Action Electrostimulation Therapy;
(13) Aversion Therapy (Includes Electric Shock for Alcoholism);
(14) Hyperbaric or Normobaric Oxygen Therapy;
(15) Narcotherapy with LSD;
(16) Marathon Therapy;
(17) Hemodialysis for Schizophrenia; and
(18) Training Analysis (Tuitional, Orthodox)

e. Individual, family or group psychotherapy rendered to a patient within twenty-four (24) hours after receiving Electroconvulsive Therapy (ECT) or Electroshock Therapy (EST).

f. Individual psychotherapy or collateral sessions with a duration of less than thirty (30) minutes. (This does not apply to physicians conducting medical management visits of their hospitalized patients or management of outpatients on drug therapy by physicians or nurses.)

g. Group, family or marital therapies with a duration of less than 45 minutes.

2. Refer claims to SECOND LEVEL REVIEW when any of the following criteria are met:

a. Diagnosis includes:

(1) Mental Retardation (DSM-III 317.0(x), 318.0(x), 318.1(x), 318.2(x), or 319.0(x));

(2) Manic-depressive illness, manic type (DSM III 296.4x);

(3) Organic Brain Syndrome; (DSM III: 290.30, 290.20, 290.21, 290.00, 290.1x, 290.4x, 303.00, 291.40, 291.80, 291.00, 291.30, 291.10, 291.2x, 305.40, 292.00, 292.83, 305.50, 305.60, 305.70, 292.81, 292.11, 305.90, 292.90, 305.30, 292.84, 305.20, 292.82, 292.12, 292.89, 293.00, 294.00, 293.81, 293.82, 310.10, 294.80)

(4) Substance Abuse/Dependence; (DSM III: 305.0x, 303.9x, 305.4x, 304.1x, 305.5x, 304.0x, 305.6x, 305.7x, 304.4x,305.9x, 305.3x, 305.2x, 304.3x, 305.1x, 304.6x, 304.9x, 304.7x, 304.8x)

(5) Pervasive Developmental Disorders; DSM III: 299.0x, 299.9x, 299.8x

(6) Anorexia Nervosa; DSM III:307.10

(7) Bulimia; DSM III: 307.51

* (8) Pica (DSM-III: 307.52) *

* (9) Rumination Disorder of Infancy *
* (DSM-III: 307.53) *

* (10) Atypical Eating Disorder (DSM-III: *
* 307.50) *

* (11) Attention Deficit Disorder; DSM III: *
* 314.01, 314.00, 314.80 *

b. Treatment procedures include:

(1) Psychoanalysis;

(2) Electroconvulsive (ECT) or electroshock (EST) therapies;

(3) Use of insulin or metrazol to produce seizures or coma;

(4) Drug therapy if:

(a) More than two psychotropic drugs are prescribed at the same time, or

(b) Patients younger than 12 years of age are receiving lithium or monoamine oxidase inhibitors;

(5) New or unfamiliar modes of treatment;

c. Individual psychotherapy or collateral sessions exceed 90 minutes. (Less than 90 minutes, pay up to 60 minutes)

d. Group, family or marital or couples (conjoint) psychotherapy sessions exceed 120 minutes. (Less than 120 minutes pay up to 90 minutes)

e. Crisis intervention claims. A Mental Health Treatment Report must accompany the claim.

f. Services are rendered in a specialized treatment facility, including (but not limited to) substance abuse facilities.

g. Individual psychotherapy services are separately being provided to two or more family members.

B. SPECIAL CRITERIA

1. Outpatient Claims

a. Case is referred to SECOND LEVEL REVIEW when:

(1) The treatment episode has reached the 24th session and every 24 sessions thereafter or every 6 months thereafter for psychoanalytic cases.

NOTE: Providers are required to complete updated CHAMPUS Treatment Reports beginning with the 24th session and at all subsequent review intervals. All outpatient treatment episodes undergo peer review upon reaching 24 sessions and 48 sessions thereafter. Claims for services rendered beyond the 24th session are held pending completion of professional review.

(2) Additional peer review or second level review has been requested by OCHAMPUS, the central Project Office, or a peer review team.

Although all cases must undergo mandatory peer review upon reaching the 24th session, the next peer review may be delayed if a special peer review was conducted during the 24th to 48th session. Peer review must be conducted 48 sessions after the initial peer review has occurred.

(3) Outpatient claims show that more than two individual, group, marital or couples, family, or collateral sessions (in any combination) were provided to the patient within the same week.

(4) Individual therapy was rendered to children younger than four years of age.

(5) Patient is under 18 years of age and receives two or more psychoactive or psychotropic medications.

2. Inpatient Claims

a. Refer to the claims history file and calculate the patient's cumulative length of stay for the current hospitalization and all hospitalizations for covered mental health services within the current calendar year.

b. Deny claims when:

(1) The patient's cumulative length of stay exceeds 60 inpatient days for a calender year; and

(2) A waiver request has not been issued by OCHAMPUS; or

(3) The additional number of inpatient days authorized by a waiver has been depleted.

c. Refer claims to SECOND LEVEL REVIEW when any of the following criteria are met:

(1) Inpatient hospitalization has reached 30 days.

(2) The patient has been readmitted within the same calendar year. (Check patient's claims history file).

(3) A special peer review has been requested by OCHAMPUS, the central Project Office, or a peer review team.

(4) The patient is six years old or younger.

(5) Claims have a sole diagnosis of one of the following:

(a) Transient Situational Disorder (DSM-III: 309.XX Adjustment Disorders;)

(b) Attention Deficit Disorder; (DSM-III: 314.01, 314.00, 314.80)

* (c) Specific Developmental Disorder; (DSM III: 315.00, 315.10, 315.31, 315.39, 315.50, 315.90) *

(d) Disorders of Impulse Control not elsewhere classified. (DSM III: 312,31, 312.32, 312.33, 312.34, 312.35, 312.39)

(6) Individual, marital or couples, family, and group therapies plus collateral sessions combined exceed five hours or five sessions per week.

(7) Patient participates in more than one psychotherapy session per day (individual, couples, family, or group).

3. Psychological Testing and Assessment

a. Deny cases when:

(1) Self-administered tests are given to patients 12 years of age or younger.

(2) Reitan-Indiana battery administered to patients four years of age or younger.

b. Pay up to the limits specified below and deny services in excess of the limits:

(1) More than three self-administered tests are given to the patient in a 12-month period;

(2) Testing totals more than four hours per beneficiary in a 12-month period (except if neuropsychological battery);

(3) Self-administered tests exceed 30 minutes per test;

(4) Intellectual or achievement tests exceed two hours;

(5) Provider administers more than four hours of testing (total) for a family undergoing conjoint or family therapy in a 12-month period;

(6) Assessment exceeds six hours in a 12-month period (except if neuropsychological battery);

(7) Total assessment time for a family undergoing conjoint or family therapy exceeds six hours in a 12-month period (except if neuropsychological battery).

NOTE: Definition of assessment includes testing (see page A-3-24)

c. Refer to second level review when:

(1) The tests do not appear on the "Selected Standard Psychological Tests" (Chapter 3, Section IV) list;

(2) Neuropsychological battery was administered;

(3) Testing does not occur at the beginning of treatment (within the first eight sessions).

III. SECOND LEVEL REVIEW

Introduction - Second level reviewers are central to OCHAMPUS' peer review system since they: 1) Review mental health cases which have been screened by first-level reviewers; 2) Coordinate and manage peer review; and 3) Make final reimbursement decisions.

This section focuses on the screening of mental health cases by second-level reviewers. Guidelines pertaining to patient management and patterns of practice are references for second level reviewers when they monitor all inpatient and outpatient mental health treatment episodes. Special criteria relating to specific diagnoses,

testing and assessment, treatment modalities, and modes of treatment are additional guidelines and should be referred to, whenever appropriate. These explicit guidelines allow second level reviewers to minimize the number of cases sent to peer review by referring only those which do not conform to clinical guidelines.

Second level reviewers cannot monitor mental health care unless information regarding the beneficiary's treatment episode is adequately documented. Providers are responsible for supplying second and third level reviewers with a coherent and logically-consistent report conceptualizing problems, goals and treatment strategies. Although the amount and type of background information required to understand the nature, cause and severity of the patient's medical or psychological condition will vary on a case-by-case basis, the successful operation of OCHAMPUS' peer review program relies on the providers' ability to articulate and summarize relevant aspects of the treatment episode.

CHAMPUS treatment reports are critical to this peer review system since they convey such vital information as: the patient's diagnosis and mental status; the goals of treatment; progress to date; and, rendered or planned interventions. To minimize the number of cases that are sent to peer review, second level reviewers consider this information in light of professionally-defined guidelines referred to as core and special review criteria. The core criteria, which are pertinent to all inpatient and outpatient treatment episodes, contain treatment guidelines relating to patient management and patterns of practice. Special criteria instruct second level reviewers to pay particular attention to cases with selected diagnoses, treatment modalities or settings, and psychological testing and assessment.

A. CORE CRITERIA

1. Patient history, assessment and diagnosis

a. Deny claims only if the information found on the treatment report does not contain a DSM-III diagnosis, reference to the nature and severity of the patient's dysfunction.

b. All CHAMPUS treatment reports must include the detailed information below.

  (1) Information regarding the chief complaint and symptoms, including date(s) of onset (including similar past episodes) and type(s) of functional impairment in at least one of the following areas:

    (a) Bodily functions - pertaining to medical, organic, or physical dysfunctions;

    (b) Psychological functions - including impaired cognition, feeling states or behavior causing the patient (or patient's significant others) a high level of personal distress. Intervention to prevent harm to the patient or others may be necessary;

    (c) Social/cultural interactions - when an individual is unable to develop or maintain social interactions or relationships, thus precluding or seriously inhibiting his/her participation within social or cultural units such as friends, co-workers, classmates, or neighbors; or,

    (d) Life tasks - when the dysfunction prevents an individual from engaging in normal activities, such as work, school, housekeeping, or severely alters the performance of such activities.

  (2) Description of factors (physiological/medical, cognitive, social/environmental/cultural, economic) contributing to patient's distress.

  (3) Current mental status information must relate to:

(a) Attitude and general behavior (i.e. health and appearance, habits of dress, general mood, use of leisure time, degree of sociability, or speech);

(b) Attitude and behavior during interview, (i.e. cooperativeness, poise, facial expression, motor activity, mental activity, emotional reactions, or trend of thought); or

(c) Sensorium, mental grasp, and capacity (i.e. orientation, memory and retention, school and general knowledge, estimate of intelligence, abstraction ability, test of absurdity, or judgment).

(4) DSM-III diagnosis must be provided. The principal diagnosis should not be among those excluded by CHAMPUS.

c. Refer cases to PEER REVIEW when there is a(n):

(1) Absence of medical referral (physician) for patient's who have:

(a) Significant somatic complaints;

(b) Significant lack of reality contact;

(c) Severe under or over physical/behavioral activity;

(d) Acute intoxication or continued alcohol or drug abuse; or,

(e) Been prescribed psychopharmacologic drugs.

(2) A change in diagnosis or problem specification from a previous treatment report is observed without an accompanying explanation.

(3) No indication of significant functional impairment as generally described in Section V of Chapter 3 of this manual.

2. Goals of Psychotherapy

Goals link future interventions to the desired outcomes of treatment. The underlying objective of psychotherapy is the restoration or improvement of the patient's somatic and/or cognitive health to the highest possible level of adaptive functioning.

Goals are also basic to the development and subsequent evaluation of treatment plans. Recognizing that medical and/or psychological interventions are dynamic processes which continuously adapt to the patient's changing needs and internal and external resources, goals require periodic reassessment.

a. Refer cases to peer review when treatment goals meet the following criteria:

   (1) Appropriateness of Stated Treatment Goals and Objectives

      (a) Goals are not practical given the patient's current mental status, functional competency or personal comfort;

      (b) Goals are not attainable by means of psychological services;

      (c) Substantial changes in goals from prior service plans are not thoroughly explained; and,

      (d) Goals are not reformulated when there is little or no progress from the last review point (unless an explanation is offered).

   (2) Measurement of goals

      (a) Goals are not stated according to specific short- (by next review point) and long-term (marking termination of treatment) objectives and

      (b) Goals are not stated in terms of observable and reportable behavior.

3. Planned or rendered services

Treatment plans document the frequency and types of interventions which are planned or initiated to eliminate or reduce the severity of the dysfunction(s). Interventions may take one of three forms: 1) Diagnostics; for the purpose of collecting additional information by means of collateral visits, physical examinations, lab tests, or psychological tests; 2) Treatment; including individual, marriage or couples, family, group, or psychiatric-somato therapies or collateral sessions; or 3) Patient Education; for the purposes of assisting patients to understand principles of mental health, develop ways of coping with mental health problems and improve their adherence to an established treatment plan.

a. DENY claims when planned or rendered services meet one of the following:

   (1) The type of therapies and/or interventions are not clearly documented following development;

   (2) Treatment interventions are excluded by CHAMPUS (See Chapter 2, First Level Review, A., 1., d.)

   (3) The frequency and length of sessions are not documented.

b. Refer claims to peer review when:

   (1) Inpatient hospitalization has reached 30 days;

   (2) Planned or rendered treatment is not consistent with the patient's diagnosis, history, prognosis, and stated treatment goals and objectives.

   (3) Child and Adolescent Therapies

      (a) Claims are for children younger than four years old.

      (b) Inpatient claims for patients under 18 years of age do not indicate that a minimum of two individual or group psychotherapy sessions per week were provided (of which one session must be individual psychotherapy).

(4) Collateral Treatment

(a) Collateral sessions are held with person(s) who are not significant individuals in the patient's life. Examples of significant individuals are spouse, parents, siblings, grandparents, guardians, or teachers.

(b) Purpose of collateral visit does not appear to be for information gathering or related to the implementation of treatment goals.

(c) Inpatient collateral visits occur less than once per month.

(d) Collateral sessions where the identified patient is not participating in individual or group psychotherapy.

(5) Group Therapy

(a) Size of group does not fall within range of 4 to 10 participants (exceptions to this may occur for group therapy sessions with children, adolescents or couples).

(b) Sessions have more than one member of the same family (except for multi-family group or marital or couples group therapy).

(6) Substantial changes in treatment procedures are not adequately documented in treatment report.

c. Frequency of Sessions

(1) The regulation stipulates that additional therapy sessions beyond the established limits may be coverable if determined to be medically/ psychologically necessary. This needs to be determined by review. Second level may deny excess and pay up to the limits if medical/psychological necessity for sessions beyond the established limits is not determined:

(a) Outpatient psychotherapy sessions (of any kind) exceed two per week (includes collateral visits)

(b) Inpatient psychotherapy sessions (of any kind) exceed five one-hour sessions per week (includes collateral visits)

NOTE: If the second level reviewer feels it is appropriate, these can be referred to peer review.

(2) Refer claims to peer review when:

(a) Individual outpatient psychotherapy sessions are not conducted at least once every two months.

(b) Individual psychotherapy sessions exceed four per family member when concurrent with family therapy conducted by the same provider or multiple providers.

(c) Multiple sessions occurring on the same day. (A collateral visit provided on the same day that the patient receives individual or group psythotherapy is coverable.)

(d) Individual psychotherapy of more than four sessions for one individual in a family when concurrent with individual psychotherapy provided other family members by the same provider or multiple providers.

4. Progress of Treatment

Clear and concise documentation of the progress of treatment is essential for gauging the effectiveness of therapeutic interventions as well as the patient's response to treatment.

a. DENY cases when documentation of progress does not contain a chronological synopsis. Documentation of progress should record the patient's behavioral or cognitive changes from the beginning of treatment (if first review point) or the last review interval.

b. Refer cases to peer review when documented progress does not relate to established goals. The peer reviewer should be asked to re-evaluate goals of treatment and psychotherapeutic interventions.

5. Termination of Treatment

A summary as to why the provider has discontinued rendering treatment to a patient serves to clarify the reasons for closure (such as attainment of treatment goals, patient relocation or other specified reasons).

In addition, aftercare plans may be appropriate for some patients recovering from severe emotional or behavioral dysfunctions who require continued treatment or support. When providers consistently omit aftercare plans from the final treatment reports of these patients, a pattern of of the provider's practice needs to be considered utilizing existing OCHAMPUS guidelines.

6. Patterns of Practice

a. DENY claims when:

(1) Psychotherapy or testing was not done face-to-face with the patient or collateral (i.e.,by telephone, video or tape recordings).

(2) A provider submits a claim(s) for time spent in consultation with or supervision of another mental health provider.

b. Refer claims to peer review when:

(1) Services are unusual or unorthodox.

(2) Patient receives same or similar services from more than one provider (Note: Obtain a treatment report from each provider); or,

(3) There is no evidence of coordination of care when the patient receives different services from more than one provider.

B. SPECIAL CRITERIA

1. Alcohol Abuse/Dependence

a. Inpatient hospital care for alcohol detoxification, stabilization, and treatment of complications.

(1) DENY cases when:

(a) Liver function and chemical screen tests have not been administered to patient.

(b) Patient's neurological examination results are not documented.

(c) The patient has exceeded the lifetime limit of three rehabilitation episodes. The lifetime limitation applies to services received on or after June 1, 1977.

(2) Refer cases to peer review when:

(a) Inpatient hospital care does not appear to be medically necessary. Emergency and inpatient hospital services are covered when medically necessary for the active medical treatment of alcohol withdrawal (detoxification), for stabilization, and for treatment of medical complications of alcoholism. Emergency and inpatient hospital services are considered medically necessary only when the patient's condition is such that the personnel and facilities of a hospital are required.

(b) Length of inpatient hospital services exceeds seven days. Any case of inpatient hospital care which continues beyond seven days is subject to prepayment review to determine whether the longer stay is medically necessary given the patient's medical condition (DoD 6010.8-R).

(c) The patient is admitted for his/her third episode of inpatient hospital services.

b. Rehabilitative care in an authorized alcohol rehabilitation facility is covered on either a residential or partial care basis. Each eligible CHAMPUS beneficiary is entitled to three alcoholism treatment benefit periods in a lifetime. A benefit period begins with the first date of alcoholism treatment and ends 365 days later, regardless of the total services actually used within the benefit period. Emergency and inpatient hospital services do not constitute alcoholism treatment for purposes of establishing the beginning of a benefit period. (DoD 6010.8-R) When the patient is medically in need of detoxification, but does not require a general hospital setting, up to seven days of detoxification are covered in addition to the 21 days of rehabilitative care.

(1) DENY claims when:

(a) Aversive therapy is used.

(b) More than three benefit periods have been used.

(c) Detoxification services in a rehabilitative facility exceed seven days.

(2) Allow partial payment up to the regulatory limits, deny care exceeding limits when:

(a) Rehabilitative care exceeds 21 days in a benefit period.

(b) Outpatient services for alcoholism exceed sixty visits in a benefit period.

(c) Family therapy for alcoholism exceeds 15 visits in a benefit period.

NOTE: Liver function, chemical screen and neurological exams should be provided on the basis of medical necessity during rehabilitative stays.

(3) Refer claims to peer review when the medical necessity of rehabilitation or detoxification services is not adequately documented.

2. Drug Abuse/Dependence

a. Rehabilitation Care

(1) Rehabilitation care in an authorized treatment facility is covered on an inpatient and outpatient basis.

(2) Refer case to peer review when:

(a) The patient is admitted for the second inpatient rehabilitation stay within a 12-month period.

(b) Patient is 12 years of age or younger and admitted to an inpatient rehabilitation program.

(c) Rehabilitation treatment exceeds 30 days.

b. Drug detoxification (including newborn addicted infants) is a benefit. Medical supervision is required.

Refer cases to peer review when:

(1) Inpatient detoxification does not appear to be medically necessary;

(2) Length of detoxification exceeds seven days; or

(3) The patient is admitted for drug detoxification for his/her third time within 12 months.

3. Eating Disorders

* a. Refer all inpatient claims with a DSM-III *
* eating disorder diagnosis to peer review. *

4. Mental Retardation

a. DENY cases if:

(1) The primary diagnosis is mental retardation and the only services rendered are excluded by CHAMPUS, such as:

(a) Custodial care.

(b) Special education or habilitative services have been rendered. These services are coverable under CHAMPUS' Program for the Handicapped only.

b. Refer cases to peer review if there is evidence that the patient may have other mental or emotional conditions requiring psychotherapy. The mental health provider must be requested to complete a CHAMPUS Treatment Report.

5. Organic Brain Syndrome

Cases with a diagnosis of organic brain syndrome will be sent to peer review, except for the circumstances outlined below. Second level reviewers must request providers complete and return a CHAMPUS Treatment Report to them upon receiving such claims.

a. Services may be limited or denied at the second level when care meets the folowing conditions:

(1) Services include CHAMPUS-excluded interventions, such as:

(a) Custodial care.

(b) Use of normobaric or hyperbaric oxygen therapy.

(c) Special education or habilitative services.

(2) Psychotherapy is rendered to patients who do not appear to have sufficient cognitive resources to respond favorably to treatment.

6. Pervasive Developmental Disorders (299.0x, 299.9x, 299.8x)

a. Cases with a diagnosis of pervasive developmental disorder will be referred to peer review, except for the circumstances outlined below. Second level reviewers will ask the providers to complete and return a CHAMPUS Treatment Report.

b. Services may be limited or denied at the second level when care meets the following conditions:

(1) Services are excluded by CHAMPUS, such as:

(a) Custodial care.

(b) Special education or habilitative services.

(2) Psychotherapy is rendered to patients with pervasive developmental disorders who do not demonstrate sufficient cognitive resources to respond favorably to treatment.

7. Transient Situational Disturbance (Adjustment Disorders) (309.00, 309.24, 309.28, 309.300, 309.40, 309.23, 309.83, 309.90)

a. Refer inpatient cases with a diagnosis of adjustment disorders to peer review if the patient has been admitted for this diagnosis in the previous 12 months and any of these previous hospitalization periods were for more than 14 days. This could signal an inappropriate diagnosis. Refer to the medical claims history file for each case with this diagnosis.

8. Psychological Testing and Assessment

a. DENY:

(1) When neuropsychological battery was administered without evidence of a referral relating to neuropsychological/cognitive questions.

(2) When Reitan-Indiana battery are administered to patients four years of age or younger.

(3) Self-administered tests that are given to patients 12 years of age or younger.

*

b. Refer cases to peer review when.

(1) Testing does not occur at the beginning of treatment (within the first eight sessions) or upon referral from another professional;

(2) Testing/assessment does not appear necessary for the determination of appropriate treatment or other disposition.

c. Second level reviewers may authorize partial payment (pay up to the limits specified below and deny testing and assessment which exceeds the limits) when:

(1) Neuropsychological battery exceeds five hours in a 12-month period;

* (2) Assessment for neuropsychological battery exceeds seven hours in a 12-month period. *

* d. Second level reviewers may authorize payment for generally accepted psychological tests that are not on the "Selected Standard List" when such testing was medically necessary. Questionable testing must be referred to peer review. *

9. Crisis Intervention

Crisis intervention may occur when there is an abrupt, substantial change in behavior caused by a clear precipitating situation resulting in severe impairment of functioning or a marked increase in personal distress requiring professional intervention(s).

a. Refer crisis intervention cases to peer review when the information does not clearly demonstrate that a crisis did in fact exist.

b. Partially pay claims up to the specified limit when:

(1) The length of crisis sessions for individual therapy exceeds two hours per day; or

(2) Family or conjoint sessions for crisis exceeds three hours per day; or

(3) More than eight hours of crisis intervention have been rendered per treatment episode. (The patient has the option of following-up with psychotherapy sessions after the crisis episode.)

NOTE: A completed CHAMPUS Treatment Report should accompany all crisis intervention claims.

10. Electroconvulsive/Electroshock Treatments

a. DENY cases when formal individual or group psychotherapy (as opposed to a medical oversight visit by a physician or psychiatric and mental health nurse specialist) has been provided on the same day.

b. Refer cases to peer review when:

   (1) Electroconvulsive or electroshock therapy is administered to patients with a diagnosis of:

      (a) Behavior disorder;

      (b) Substance abuse;

      (c) Organic mental disorders;

      (d) Psychosexual disorders; or,

      (e) Adjustment disorders.

   (2) The patient is under the age of 18 years of age.

c. Partially pay claims (up to the specified limit) when:

   (1) More than one ECT or EST was administered to a patient within a 24-hour time period or

   (2) More than 20 ECTs or ESTs were administered to a patient within a consecutive 30-day period.

11. Psychoanalysis

After an analyst has examined his/her patient and has established a diagnosis for which psychoanalysis is the designated mode of treatment according to the model criteria described in the Manual of Psychiatric Peer Review, Part Two (American Psychiatric Association, January 1981, "Psychoanalytic Peer Review"), s(he) must obtain authorization (diagnosticreview) using a CHAMPUS Authorization Form for Psychoanalysis. Authorization should be initiated immediately following diagnostic formulation.

Peer review is conducted at the 24th, and 72nd sessions, and every six months thereafter. This review is completed from the followup progress summary.

a. Refer cases to peer review when:

(1) A provider plans to render psychoanalysis to a patient. Obtain completed CHAMPUS Authorization Form;

(2) The 24th or 72nd psychoanalytic treatment episode has reached the outpatient session (a mandatory review point); or,

(3) Treatment continues for six month intervals beyond the 72nd session.

12. Drug Therapy Criteria (See also Appendix 6, "Model Psychopharmacologic Criteria ")

a. Refer both inpatient and outpatient cases to peer review if:

(1) Patient is receiving more than two psychotropic drugs;

(2) Patient is less than 12 years of age and receiving:

(a) Lithium or

(b) Monoamine Oxidase Inhibitors;

(3) The diagnosis is manic-depressive illness, manic type (DSM-III 296.4x) and the patient is not being treated with either Lithium or a major tranquilizer;

(4) Insulin has been used to produce coma or sub-coma; or

(5) Metrazol was administered as a convulsive agent.

b. Refer outpatient claims to peer review when patient is under 18 years of age and receiving two or more psychoactive or psychotropic medications

c. Refer inpatient cases to peer review when:

(1) The diagnosis is: involutional melancholia (DSM-III 296.23); manic-depressive illness, depressed type (DSM-III 296.5x); psychotic depressive reaction (DSM-III 296.24); schizophrenia (DSM-III 295.0); or,

schizophrenia, schizo-affective type, depressed (DSM-III 295.70) and

(2) The patient is 18 years of age or younger and inpatient chemotherapy includes either:

(a) An antidepressant medication;

(b) An antipsychotic medication;

(c) Lithium; or,

(d) Electroconvulsive therapy.

13. Treatment Setting

a. Partial hospitalization is not generally covered under CHAMPUS' Basic Program. (The exception is for the treatment of alcoholism. Rehabilitative care in an authorized alcohol rehabilitation facility is covered on a partial care basis.)

(1) Partial payment for non-alcoholism treatment claims, may be made in the following manner:

(a) Identify CHAMPUS-approved therapies (such as individual, group or collateral sessions);

(b) Adjudicate claim only for approved services/treatment if procedures are consistent with CHAMPUS regulations and the guidelines set forth in this manual; and

(c) The provider must be a CHAMPUS-authorized provider.

IV. THIRD LEVEL REVIEW

* Third level review may be conducted internally (onsite) at the * fiscal intermediary when internal review has been authorized by OCHAMPUS or externally (through mailings).

A. Why cases are referred to peer review.

All ongoing mental health services provided to CHAMPUS beneficiaries are subject to professional review to assess their medical or psychological necessity and appropriateness of care. Cases are referred to peer review when:

1. Services rendered are not consistent with the criteria set forth in this manual for the provision of inpatient and outpatient mental health care;

2. The treatment episode has reached a mandatory review interval. The outpatient peer review interval is scheduled for the 24th, 72nd and every 48th session thereafter. All inpatient care is peer reviewed at the 30th inpatient day;

3. A special peer review interval has been recommended by peer review, OCHAMPUS, the Central Project Office, or second level review.

4. A provider is seeking preauthorization. This will occur when a waiver request was submitted to OCHAMPUS to extend an inpatient stay beyond the 60-day limit.

B. Requesting submittal of treatment reports from providers or beneficiaries.

When any of the previously-cited conditions exist, the second level reviewer must request that the provider complete a CHAMPUS Treatment Report (or an OCHAMPUS Authorization Form for Psychoanalysis, when appropriate). This request should be accompanied by a postage-paid, pre-addressed envelope to the second level reviewer (or his/her designee) and marked CONFIDENTIAL - Do Not Open in Mail Room.

* Controlled development standards outlined in the COM-FI, * Part 2, Chapter 1, paragraph V.B.3., shall be adhered to, except that the FI may use case file development and denial on mental health claims, only, where the CHAMPUS Treatment Report is required and not received on a timely basis. For example, claim #1 is received and a CHAMPUS Treatment Report is requested. All subsequent mental health claims for that beneficiary shall be suspended pending a response for that beneficiary. If the request was directed to a nonparticipating provider, on the 30th day or the workday immediately preceding the 30th day the FI shall contact the beneficiary and allow up to 15 additional days for reply. All suspended mental health claims for that beneficiary may be denied for lack of information after the 35th day for participating providers and after the 45th day for nonparticipating claims. The claimant shall be advised that no payment can be made until the required CHAMPUS Treatment Report is received. * *

Second level reviewers should request additional information from providers if the treatment report is not satisfactorily completed or if clarification of selected items is indicated, particularly if the case is to be referred to peer review.

C. Selection of Peer Reviewers

1. Second level reviewers (or their designees) are responsible for selecting one peer reviewer (except as defined in C.1.c. in this section) from a roster of trained peer reviewers compiled by the American Psychiatric and Psychological Associations, the American Nurses' Association and the National Association of Social Workers. (Fiscal intermediaries provide third level review for marriage and family therapists and pastoral counselors - see Part 2 of the COM-FI, Chapter 2, IV.K.4.c.) Fiscal intermediaries should consider the following guidelines when selecting a reviewer:

   a. The peer reviewer must be from the same mental health discipline as the provider undergoing review. Thus, physicians, psychologists, clinical social workers, and certified psychiatric nursing specialists review cases of their peers. Two exceptions to this guideline exist:

      (1) Peer reviews of psychological testing and assessment cases are conducted only by psychologists, regardless of the category of provider; and

      (2) Peer reviews of cases for marriage and family therapists or pastoral counselors are conducted by FIs with professional consultative staff in accordance with this policy instruction.

      (3) When multiple providers are involved (such as when a certified psychiatric nursing specialist is providing individual psychotherapy to a patient who is also being treated with psychopharmacologic medication), the case will be reviewed by a certified psychiatric nursing specialist and a psychiatrist. Similarly, inpatient treatment episodes under the supervision of a psychiatrist but also receiving testing and assessment by a clinical psychologist are to be reviewed by a psychiatrist and a psychologist (the latter specializing in testing and assessment).

b. Every effort should be made to find a reviewer inthe same state as the provider. If a reviewer is not available in that state, then one should be chosen from a geographic area close to the state.

c. The selected peer reviewer should practice within the same subspeciality area as the provider being reviewed. Thus, if the case pertains to child therapy, the peer reviewer shall specialize in child therapy. The same is true for cases involving adult/adolescent, marital or couples, behavioral, or family therapies, plus psychoanalysis and formal psychological testing.

d. Rotate Reviewers. Do not consistently assign the same reviewer to new cases. All peer reviewers were carefully screened and care should be taken to equitably distribute the workload. However, reassign the same reviewer for follow-up reviews of the same case.

e. Avoid potential conflicts of interest. Do not select a reviewer who works in the same organized care setting as the provider undergoing review. This can be avoided by referring to the Roster of Peer Reviewers to verify that the reviewer's organizational affiliation and business address do not match those of the provider undergoing review.

f. Expeditiously select reviewer replacement(s). In the event that a conflict of interest does arise or the originally-assigned reviewer is unavailable, the second-level reviewer should immediately find a replacement and notify the Central Project Office.

NOTE: For peer review of marriage and family therapists and pastoral counselors, the fiscal intermediary will provide a consultant specialist to provide third level review in accordance with the this instruction.

D. Responsibilities of Reviewers

1. Administrative Responsibilities

a. Reporting of Absences. In order to avoid unnecessary delays, all peer reviewers shall provide the FIs with timely notification (either by phone or letter) when they will not be available to review cases for 7 days or more due to illness, travel or other circumstances.

b. Voluntary Disqualification. If a peer reviewer recognizes either the patient or provider from the (sanitized) CHAMPUS Treatment Report, they shall immediately contact the FI regarding this discovery. Similar measures should be taken when a reviewer determines that they are not competent to review the type of treatment being provided;

c. Reporting of Suspected Incompetence or Unethical Behavior. If a peer reviewer has reason to believe that the provider is demonstrating professional incompetence (i.e. knowingly behaving in a way that is injurious to the patient) or engaged in conduct which may constitute a serious violation of the profession's ethical standards, the reviewer should provide a brief statement to this effect on a separate piece of paper. The FI must report this information to OCHAMPUS' Office of Quality Assurance through the Office of Program Integrity.

2. Technical Responsibilities

a. Informal Consultations. Peer reviewers shall make themselves available to FIs when the latter have technical questions regarding diagnoses, services planned or rendered or other related patient management information. Informal consultations are encouraged in the hope that they may increase the level of understanding between peer reviewers and second level reviewers. Peer reviewers may be reimbursed for their time.

b. Recommendations for Adjudication of Claim. FIs make final determinations regarding payment or nonpayment of services rendered. However, peer reviewers facilitate this process by making recommendations on the appropriateness and necessity of care. These recommendations assist second level reviewers in making benefit decisions.

c. Disposal of Clinical Information. Upon completion of professional review, the peer reviewer should dispose of all treatment and peer review reports by tearing them up and throwing them away. This is required to protect the confidentiality of patients and providers. However, s(he) may retain one copy of his/her peer review report for personal reference. One copy each of the recently completed Peer Review Report must be sent to the FI and the central Project Office.

E. Procedures for Submitting Case Material to Peer Reviewers

1. Confidentiality and Document Handling

The treatment report and all other documents sent to peer reviewers or the central Project Office are confidential. Their use is subject to the following guidelines:

a. Authorized Personnel Only. The use of all review documents is restricted to authorized utilization and peer review personnel. Documents are to be retained within the utilization and peer review office of the FI in a secure file, separate from the claims history file;

b. Sanitization of Treatment Reports. All patient and provider identifying information is to be removed from treatment reports and any other documents sent to peer reviewers or to the central Project Office. Patients' last names should be removed from treatment reports. If the patient has an unusual first name, his/her initials may be used instead.

c. Assignment of Case Code Number. All beneficiaries are identified by means of a case code number assigned by the second level reviewer. Whenever the FI receives a treatment or peer review report (or other supporting information) on behalf of the beneficiary, it should be identified with the appropriate case code number. The first two digits represent OCHAMPUS state code numbers corresponding to the provider's state and the last three numbers represent the FI's internal code. FIs must retain the same case number for re-reviews. However, subsequent reviews may be differentiated by adding decimal points to the original peer review case code number (i.e. 43050.1, 43050.2, 43050.3);

d. Key to Case Code Numbers. The key to patient identifying data must be maintained separately and securely from all clinical reports;

e. Correspondence. All correspondence between the FI, peer reviewers, and the central Project Office should be marked: CONFIDENTIAL - Do Not Open In Mail Room; and,

f. No Storage of Peer Review Information. FI personnel are prohibited from microfilming or transferring review materials to computerized data files.

2. Submission of Information to Peer Reviewers

Second level reviewers (or their designees) will assemble and transmit copies of the following material to each member of the review team. A copy of the package sent to peer review shall be forwarded to the Central Project Office (contractor responsible for managing and appointing peer reviewers).

a. Copies of all CHAMPUS Treatment Reports submitted by the provider for the treatment episode of care. The treatment reports shall be stapled together with one staple and arranged in chronological order (beginning with the oldest report on top and ending with the most recent one). Face sheets identifying the names of the provider and patient shall be removed from each treatment report. If the treatment report was submitted in narrative form, second level reviewers should also be sure to remove the name and address of the provider from each page (check both top and bottom of page, especially when provider uses personal stationary);

b. Copies of prior peer review reports. Names of previous peer reviewers should be removed. The peer review reports should also be arranged in chronological order, with the oldest report on top;

c. One copy of the peer review report, to be used by the reviewers for reporting the results of their review back to the second level reviewer. The second level reviewer will complete Part A of the report. The peer review report includes only the name and code number of the reviewer;

d. A pre-addressed, postage-paid envelope addressed by name to the second level reviewer (or his/her designee) within the FI's office. This envelope is to be used by the peer reviewer to return a copy of his/her completed report back to the FI. The envelope should be clearly marked CONFIDENTIAL - Do Not Open In Mail Room; and,

e. A pre-addressed, postage-paid envelope addressed to the Central Project Office. This envelope will be used by the peer reviewer to send one copy of the peer review report to the Project Office as notification that the review has been completed. This envelope should also be clearly marked CONFIDENTIAL - Do Not Open In Mail Room.

F. FI Final Determinations

1. Receipt of Peer Review Reports

Peer reviewers are requested to complete and return their reports within seven consecutive days of the date of receipt of the case materials. If the second level reviewer (or his/her designee) has not received a report 15 consecutive days after the date the materials were sent, the FI may phone the reviewers requesting expeditious completion of the review. Problems in obtaining completed, useful reviews should be directed to the Central Project Office for follow-up.

2. Informal Consultations

If the second level reviewer requires clarification of any aspect of the peer review report, (s)he may telephone the peer reviewers to discuss the matter of concern. However, it is inappropriate for the second level reviewer to attempt to obtain a change in the peer reviewer's original opinion or to provide additional case information. All relevant facts necessary for review should be submitted with the initial request for peer review.

3. Final Determinations

Second level reviewers, (not peer reviewers), make final determinations regarding payment, denial, or partial payment of claims for rendered or planned services. When exercising their judgment, second level reviewers should remember the following guidelines:

a. The FI's final determination should normally correspond with the recommendation of the peer reviewer. However, exceptions might exist if, in the opinion of the FI, the peer reviewer's recommendations runs contrary to OCHAMPUS regulations or other special circumstances;

b. Denial of claims must be based upon either substantial noncompliance with a criterion or lack of information (reflecting a significant deficit in the description of treatment provided); and

c. The FI shall not attempt to resolve differences of professional opinion.

G. Documentation of Final Action

1. All final decisions will be documented in writing by the second level reviewer. Copies of peer review reports should not be sent to beneficiaries. However, the FI may excerpt language from the report to support their determination.

H. Feedback to Providers

1. Peer review is an excellent opportunity for providers to learn how their colleagues would manage a case under similar conditions. As a result, second level reviewers (or their designee) will forward a copy of Parts B and C of the Peer Review Report (with the nameand code number of the reviewer removed) to the provider whose case was reviewed.

I. Retention of Peer Review Reports

The second level reviewer (or his/her designee) should retain one complete set of all peer review case material for appeal, reference and audit purposes. Treatment reports submitted by providers or beneficiaries for peer review purposes will be retained by the FI only so long as required for claims adjudication or appeal.

Treatment reports will be subsequently forwarded to the Federal Record Center in accordance with OCHAMPUS specifications.

J. The Second level reviewer will complete the FI ADJUDICATION LOG and mail it within five working days of completion of case to the Central Project Office. FI's will maintain a copy of the log with the peer review report in their files. The adjudication log for third level review of marriage and family therapists and pastoral counselors will be maintained by the FI.

CHAMPUS POLICY MANUAL

VOLUME II

UTILIZATION REVIEW OF MENTAL HEALTH SERVICES

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CHAMPUS TREATMENT REPORT

CHAMPUS TREATMENT REPORT

A. To be COMPLETED by the FISCAL INTERMEDIARY

1. Case Number:________________ 2. State Code: ________________

3. F.I.: ____________________ 4. Second Level Reviewer__________

5. FI Reviewer's Phone ________ 6. Date case sent to review_/_/_

7. Patient's D.O.B.:___________ 8. Sex: Male___, Female___

9. Patient's Marital Status: Single___, Married___, Separated___,
Divorced___, or Widow(er)___.

10. Date treatment began_/_/_.11. Date treatment ended_/_/_.

12. Number outpatient sessions___ or Inpatient Days ___ to date.

13. Treatment Setting:

a. Outpatient:

-- Therapist's Office

__ Hospital Clinic

__ C.M.H.C.

__ Other

b. Inpatient:

__State or County Mental Hosp.

__Other inpatient Psychiatric Facility

__Alcohol or Drug Abuse Facility

__Nursing Home or Extended Care Facility

__Other Residential Setting (Specify)

____

14. Primary Therapist:
___M.D. or D.O., ___Clinical Psychologist
___Marriage and Family Therapist ___ Clinical Social Worker
___Psychiatric Nurse Specialist ___Pastoral Counselor
___ Other ______________

Figure-1

CHAMPUS TREATMENT REPORT

CHAMPUS TREATMENT REPORT (Page 2)

B. TO BE COMPLETED BY THE PROVIDER

INSTRUCTIONS:

This treatment report is completed at the 24th session of outpatient care or on or before the 30th inpatient day. Subsequent reports may be provided using the Follow-up Progress Summary. If psychoanalysis is the primary treatment modality, then the authorization form for psychoanalysis must be completed.

The patient has signed an authorization to release information as part of the process of filing a claim with CHAMPUS. However, the provider is encouraged to discuss the nature and contents of this report with the patient. CHAMPUS Regulation 6010.8-R does require review of all inpatient and outpatient mental health services by the fiscal intermediary to include peer review.

Please respond to all items. Additional documentation, such as a narrative or hospital chart (all or part), may be submitted to supplement the information contained in this report.

*NOTE: Accurately completing this form plus providing supportive *
* or collaborative information will expedite processing of *
* your claims. A narrative will not be accepted in lieu of completion of the CHAMPUS Treatment Report.

Figure-1 (continued)

CHAMPUS TREATMENT REPORT

B. Continued.

1. Diagnosis: Use DSM-III Codes only

Mandatory (All axis)

Axis I
a. ____________________
b. ____________________

Axis II ________________

Axis III ________________

Axis IV 1 2 3 4 5 6 7 8
(Circle Appropriate #)

Axis V 1 2 3 4 5 6 7 8
(Circle Appropriate #)

2. Presenting Symptoms
Describe symptoms (distress) and functional impairments for which patient sought care.

Check severity of patient's dysfunction:
___Mild, ___Moderate, ___Severe

3. Historical Data:
Relevant history for understanding patient's current condition. If patient is less than 18 years old, include significant developmental aspects.

4. Prior Treatment Episodes:
State pertinent medical/psychological information from prior treatment epidoses.

Date(s)	Diagnosis	Interventions	Response

Figure-1 (continued)

CHAMPUS TREATMENT REPORT

5. Mental Status and Psychological Testing

   a. Provide current mental status examination.

   b. If psychological testing and assessment was conducted by you, please answer the following questions:

      1. Date of Test(s)

      2. Name(s) and time spent for each test administered

      3. What questions were to be addressed by this assessment. Please provide sufficient detail.

      4. Indicate results, conclusions, and recommendations.

6. Physical Examination. Describe significant results of physician's examination. Include pertinent laboratory examinations, abnormal findings and dates of tests. If problem includes alcoholism, provide the most recent results of neurological, liver function, and other lab tests. Give dates.

7. Evaluate Current Family and Community Support Systems.

8. Using the above data, describe the patient's current condition.

Figure-1 (continued)

CHAMPUS TREATMENT REPORT

9. Treatment and Interventions.
   a. Describe physiological And psychopharmacological treatments (include drug names and dosages).

   b. For each treatment modality, (individual, group, family, couples) specify frequency and length of sessions. If you have recently altered the treatment plan or anticipate a change, please explain.

Modality:__________________: Frequency:____/mo.; Length:____min.

Modality:__________________: Frequency:____/mo.: Length:____min.

Modality:__________________: Frequency:____/mo.; Length:____min.

   c. If outpatient treatment interventions exceed 2 per week, or if inpatient interventions exceed 5 per week, please explain.

   d. Describe the frequency and purpose of collateral contacts, (e.g., contacts with family or significant others) and ancillary services (e.g., educational/vocational).

   e. Provide your rationale for the specific level of care being provided (Inpatient and outpatient)

Figure-1 (continued)

CHAMPUS TREATMENT REPORT

10. Treatment Goals.

a. Intermediate/Short-term goals. For outpatient, what goals have been set for the next review point? Hospital treatment must end by the60th hospital day unless a waiver request is granted by Director, OCHAMPUS.

b. Long-term goals. Describe the goals expected to be reached by the end of treatment. Outpatient long-term goals are differentiated from intermediate/short-term (i.e., goals for the next review interval).

11. Termination of Treatment
What steps have been taken to prepare the patient and family for discharge form the hospital, or termination of outpatient treatment.

12. Estimated duration of treatment

______________________ ________ __/__/__
Name of Provider (please print) Degree Date

____
Street

____
City State Zip Code

(___)____________
Phone

Figure-1 (continued)

FOLLOW-UP PROGRSSS SUMMARY

FI Agent

Phone:

Previously Submitted Diagnosis
  Axis I
  Axis II
  Axis III

Peer Review Case #________

* Date __/__/__

* Review Interval ________
(Specify # sessions/days)

FOLLOW-UP PROGRESS SUMMARY

Follow-up Progress Summary Reports are addenda to the initial CHAMPUS Treatment Report and must be completed at each mandatory or special review interval. This report should contain a comprehensive summary of the patient's progress since the last report. Please include updated information if there have been significant changes to the originally submitted treatment report or prior Progress Summaries.

1. Current Condition.
   a. Describe patient's current symptoms and functional impairments.

   b. List any changes in diagnosis(es) (DSM-III codes).

2. Describe patient's progress in meeting your previously stated intermediate/short-term goals for this review interval.

3. What intermediate/short term goals have you established for the next scheduled review interval?

4. Will you modify the type or frequency of treatment interventions? If yes, please describe and explain planned changes.

5. What changes have you made in long term treatment goals?

6. Estimated duration of treatment.

____________________ __________ __________
Name of provider (please print) Degree Date

*To be completed by Second Level Reviewer.

Figure-2

PEER REVIEW REPORT
FOR
IN/OUTPATIENT MENTAL HEALTH SERVICES

Case #

PEER REVIEW REPORT
FOR
IN/OUTPATIENT MENTAL HEALTH SERVICES

PART A: TO BE COMPLETED BY SECOND LEVEL REVIEWER
Administrative Information

1. FI____________________ 2. Date Case Sent to Reviewer___/___/___

3. Level II Reviewer's Name __________________ 4. Phone ___/___/___/

5. Type of Provider: ___M.D.(Psychiatrist) ___M.D.(Specify)________
___D.O. (Psychiatrist) ___D.O. (Specify)________
___Psychologist ___M.S.W. ___M.F.T. ___P.C.
___Psychiatric Nurse Specialist

6. The number of enclosed treatment reports for this case is (including most recent and prior treatment reports): _________.

7. This is the ___1st ___2nd ___3rd ___4th peer review of this case.

8. This case has been sent to peer review because:

a. ___ Mandatory review at 24th outpatient session.
b. ___ Review of psychological testing/assessment.
c. ___ This is a mandatory peer review interval at the 30th inpatient day.
d. ___ This is a recommended review point for the ___th inpatient day.
e. ___ Previous peer review recommended follow-up at this time. (Note: previous peer review reports are enclosed)
f. ___ Provider is requesting preauthorization.
g. ___ It meets criteria for selected review (Please specify ____
____
h. ___ Other (Specify)______________________________________

Figure-3

PEER REVIEW REPORT
FOR
IN/OUTPATIENT MENTAL HEALTH SERVICES

-2-

PARTS B AND C ARE COMPLETED BY peer reviewer
(NOTE: Parts B and C will be sent to provider)

PART B: PLEASE ANSWER QUESTIONS AND PROVIDE SUPPORTING RATIONALE

1. Is the information provided sufficient to conduct the review? If not what specific information was lacking? Yes___ No___

2. Was care medically/psychologically necessary Yes___ No___

3. Was treatment, including frequency and duration of interventions appropriate for the diagnosis? Yes___ No___

4. If inpatient sessions exceeded 5 per week or outpatient sessions exceeded 2 per week, does the provider adequately explain the need for the level of care? Yes___ No___

Figure-3 (continued)

PEER REVIEW REPORT
FOR
IN/OUTPATIENT MENTAL HEALTH SERVICES

-3-

5. Is the care being provided at the most appropriate level. If not what would be the most appropriate level? Does the provider justify the level of care? Yes___ No ___

6. For psychologist reviewers only. Was psychological testing reasonable and appropriate? Yes___ No___

7. Is the patient making progress? How is this documented in CTR? If no progress, does the provider identify the obstacles and strategies for overcoming them? Yes___ No___

8. Are the treatment goals and planned interventions reasonable? Yes___ No___

Figure-3 (continued)

PEER REVIEW REPORT
FOR
IN/OUTPATIENT MENTAL HEALTH SERVICES

-4-

9. Other questions for the reviewer (See Item 8.h. part A)

PART C: PEER REVIEW
R COMMENTS

Communication between colleagues may be useful and enhance the treatment. The Reviewer offers the following comments:

Figure-3 (continued)

CHAMPUS AUTHORIZATION FORM FOR PSYCHOANALYSIS

CHAMPUS AUTHORIZATION FORM FOR PSYCHOANALYSIS

Case Number: __________

-COMPLETED BY THE PI-

PI: ____________________________ TREATMENT SETTING
SECOND LEVEL REVIEWER__________ ____ OUTPATIENT
____ INPATIENT
REVIEWER'S PHONE #: ( ) ___-___ ____ OTHER
(Specify) ____________
PATIENT'S DOB: __/__/__ TYPE OF PROVIDER
PATIENT'S SEX; __MALE __FEMALE ____ M.D. (PSYCHIATRIST)
PATIENT'S MARITAL STATUS: ____ M.D. ____ ____
____ SINGLE ____ MARRIED (Specify) ____________
____ SEPARATED ____ DIVORCED ____ D.O. (PSYCHIATRIST)
_____ WIDOW(ER) _____ D.O. (Specify)
_____ PSYCHOLOGIST
DATE TREATMENT BEGAN: __/__/__ ____ M.S.W.
NO. SESSIONS TO DATE: __/__/__ ____ M.F.T. ____ P.C.

-COMPLETED BY THE PROVIDER-

PLEASE PROVIDE INFORMATION IN RESPONSE TO QUESTIONS 1-5, AS APPROPRIATE

1. DSM-III DIAGNOSIS

   MANDATORY: (All axis)

   AXIS I ____________ AXIS IV ____________
   AXIS II ____________ AXIS V ____________
   AXIS III ____________

2. PRIMARY INDICATORS FOR PSYCHOANALYSIS

   A. CHRONIC SYMPTOMS PREDOMINANTLY REFLECTING INTRAPSYCHIC CONFLICT ARE PRESENT. USE DATA FROM (1) HISTORY; (2) ASSESSMENT OF CURRENT PSYCHOLOGICAL FUNCTIONING (INCLUDING MENTAL STATUS); AND (3) QUALITY OF INTERACTION.

Figure-4

CHAMPUS AUTHORIZATION FORM FOR PSYCHOANALYSIS

-2-

B. CHRONIC SYMPTOMS REFLECTING ARRESTED OR DEVIANT DEVELOPMENT OR PARTIALLY ABSENT STRUCTURE (WITH GROWTH POTENTIAL) ARE PRESENT.
USE DATA FROM (1) HISTORY; (2) ASSESSMENT OF CURRENT PSYCHOLOGICAL FUNCTIONING (INCLUDING MENTAL STATUS); AND (3) QUALITY OF INTERACTION.

3. QUALIFYING INDICATORS FOR PSYCHOANALYSIS. (PLEASE FILL IN ALL APPLICABLE CATEGORIES.)

A. SYMPTOMS WILL NOT RESPOND, OR WILL WORSEN, OR DEVELOPMENT WILL NOT PROCEED, WITH OTHER TREATMENT METHODS, E.G., CHRONIC SYMPTOMS EITHER EMBEDDED IN A RIGID CHARACTER STRUCTURE, OR OCCURRING IN THE PRESENCE OF FRAGILE OR BRITTLE DEFENSES WHOSE FAILURE WOULD BE THREATENING TO THE PATIENT. USE DATA FROM (1) HISTORY; (2) ASSESSMENT OF CURRENT PSYCHOLOGICAL FUNCTIONING (INCLUDING MENTAL STATUS) AND 3) QUALITY OF INTERACTION.

B. SYMPTOMS RELIEF IS ACHIEVABLE WITH OTHER TREATMENT ONLY AT EXCESSIVE PERSONAL OR SOCIAL COST (E.G., RISK OF CHRONIC DEPENDENCY UPON ANTIANXIETY MEDICATION, EVEN WHEN PRESCRIBED IN PROPER DOSAGE: OR RETREAT TO A SELF-DEPRECIATING JOB TO AVOID MASTERING ANXIETY THROUGH UNDERSTANDING). USE DATA FROM (1) HISTORY; (2) ASSESSMENT OF CURRENT PSYCHOLOGICAL FUNCTIONING (INCLUDING MENTAL STATUS); AND (3) QUALITY OF INTERACTION.

Figure-4 (continued)

CHAMPUS AUTHORIZATION FORM FOR PSYCHOANALYSIS

-3-

C. TEMPORARY RELIEF, PARTICULARLY OF ACUTE SYMPTOMS RELATED TO CURRENT STRESS, MAY BE OBTAINED WITH OTHER TREATMENT METHODS; DISABILITY) IS LIKELY TO RECUR. USE DATA FROM (1) HISTORY; (2) ASSESSMENT OF CURRENT PSYCHOLOGICAL FUNCTIONING (INCLUDING MENTAL STATUS); AND (3) QUALITY OF INTERACTION.

4. CRITERIA FOR ANALYZABILITY

A. STABLE CURRENT AND PROSPECTIVE LIFE SITUATION PROVIDING POSSIBILITIES FOR CHANGE:

B. EVIDENCE OF SUCCESSFUL SOCIAL FUNCTIONING AND ABILITY TO USE INTELLECT, E.G., IN SCHOOL, ON JOB, ETC.

C. ADEQUATE ABILITY TO COMMUNICATE THROUGH SPEECH:

D. ADEQUATE CAPACITY FOR INTROSPECTION AND ACCESSIBLE FANTASY LIFE:

Figure-4 (continued)

CHAMPUS AUTHORIZATION FORM FOR PSYCHOANALYSIS

E. ADEQUATE TOLERANCES FOR ANXIETY, FRUSTRATION, AND DEPRESSION, AND ADEQUATE IMPULSE CONTROL:

F. ADEQUATE POTENTIAL FOR SUBLIMATION:

G. CAPACITY TO TOLERATE AND TO UTILIZE THERAPEUTIC REGRESSION (ABILITY TO ALTERNATELY EXPERIENCE AND OBSERVE SELF):

H. INTERNAL OBJECT CONSTANCY:

I. ADEQUATE CAPACITY FOR SELF-OBJECT DIFFERENTIATION AND HIGH LEVEL OF REALITY TESTING:

J. ABILITY TO FORM RECIPROCAL AS WELL AS NURTURANT RELATIONSHIPS:

Figure-4 (continued)

CHAMPUS AUTHORIZATION FORM FOR PSYCHOANALYSIS

K. RELATIVE ABSENCE OF SIGNIFICANT EARLY TRAUMA.

5. PRESENT A DYNAMIC FORMULATION THAT MAKES USE OF DATA FROM THE ANALYST'S HISTORY, INTERVIEW, ASSESSMENT OF CURRENT PSYCHOLOGICAL FUNCTIONING, AND THE ANALYST'S EMPATHIC RESPONSE TO THESE. THIS FORMULATION SHOULD REFLECT THE DOCUMENTATION OF 1,2,3, and 4 USING THE FOLLOWING CATEGORIES: (1) HISTORY; (2) ASSESSMENT OF CURRENT PSYCHOLOGICAL FUNCTIONING (INCLUDING MENTAL STATUS); AND (3) QUALITY OF INTERACTION.

NAME OF PROVIDER (PLEASE PRINT) DEGREE CURRENT DATE

ADDRESS PHONE

Figure-4 (continued)

PI ADJUDICATION LOG

PI ADJUDICATION LOG

PI ____________________

Second Level Reviewer ___________

Date Case Referred: _/_/_
Date Case Received: _/_/_

Peer Review Case #: __________

Care is: _Inpatient _Outpatient

Provider Type: _ M.D. _ D.O.
_ Psychologist _ M.S.W.
_ R.N., C.S.
_ M.F.T. _ P.C.

BENEFIT DECISIONS (CHECK ONE)

		Approve	Deny	Limit (Specify # days or sessions)
Past Care	Inpatient			
	Outpatient			
Planned Care Complete Box Below	Inpatient			
	Outpatient			

MODALITIES

	Primary	Additional
Specify Type		
Additional # Sessions		
Length of Sessions		
# Sessions/Month		

The next review point is scheduled for: __/__/__

If final disposition is different from peer reviewers' recommendations, please explain.

NOTE: COMPLETE THIS FORM WITHIN FIVE WORKING DAYS OF COMPLETION OF CASE AND MAIL COPY TO CENTRAL PROJECT OFFICE.

SAMPLE LETTER FROM FIRST LEVEL REVIEWER REQUESTING ADDITIONAL INFORMATION FROM PROVIDER

Date:
Re: Treatment of
(Patient's Name)

Dear:

The CHAMPUS Claims Form(s) recently submitted by you and summarizing services of the patient named above lacks needed information. In order to continue processing this claim for payment or review, we need the following additional information:

Please supply the above-mentioned information at your earliest convenience. Failure to do so by (date) may result in a denial of the claim. A pre-addressed envelope marked to my attention is included for your convenience.

Sincerely,

(First Level Reviewer's Name)
(Phone #)

Enclosure(s):

Please refer to COM-FI, Part Two, Chapter 1, paragraph V.B.3. for complete information required on controlled return letters.

A SAMPLE LETTER TO REQUEST TREATMENT REPORTS

Dear (Provider's Name):

A CHAMPUS claim for (in/outpatient) mental health care provided by you to (patient's name) covering services from (date of first visit or inpatient day) to (date of last visit or inpatient day claimed) has been received.

Certain additional information is required on patients whose mental health treatment claimed under CHAMPUS meets certain conditions. The information requested will be used as part of our claims review process.

The paragraphs below outline the condition(s) which may apply. Please note the instructions and take the actions necessary for the processing of your claim.

___ This claim covers the ___24th ___48th ___other (___) outpatient treatment session. Further documentation is required before it can be processed. Please complete and return the attached treatment report. If it is not received by (date), the claim may be denied.

___ Previous peer review of this case resulted in the decision to review treatment again at the time of the ___th session or inpatient day (select one). In order to complete the review, it is necessary to have further documentation. Please complete and return the attached treatment report. If it is not received by (date), the claim may be denied.

____ This claim covers the 24th outpatient treatment session or the 30th inpatient day (select one). CHAMPUS Regulation 6010.8-R has designated this as a mandatory peer review interval. As a result, it is necessary to have further documentation. Please complete and return the attached Treatment Report. If it is not received by (date), the claim may be denied.

___ This claim covers services or a pattern of services which require further documentation before it can be processed. Please complete and return the attached treatment report. If it is not received by (date), the claim may be denied.

If you have any questions concerning the completion of the treatment report, please contact me at (phone number).

Sincerely,
(Second Level Reviewer's Name)

Enclosure(s):

Please refer to COM-FI, Part Two, Chapter 1, paragraph V.B.3. for complete information required on controlled return letters.

SAMPLE FOLLOW-UP LETTER TO PROVIDER REQUESTING ADDITIONAL INFORMATION

Date:
Re: Treatment of
(Patient's Name)

Dear (Provider's Name):

The treatment report recently submitted by you and summarizing services to the patient named above is incomplete. In order to continue developing this claim for review, please submit the following additional information:

We remind you that all information supplied for the purpose of claims review is held in confidence. Please supply the above-mentioned information at your earliest convenience. Failure to do so by (date) may result in a denial of current or future claims. A pre-addressed envelope marked to my attention is included for your convenience.

If you have any questions regarding the completion of the treatment report, please contact me at: (phone number).

Sincerely,

(Second Level Reviewer's Name)

Enclosure: Preaddressed envelope

Please refer to COM-PI, Part Two, Chapter 1, paragraph V.B.3. for complete information required on controlled return letters.

SAMPLE LETTER INFORMING BENEFICIARY OF REVIEW

Date:
Re: Treatment of
(Beneficiary's Name)

Dear (Beneficiary or Sponsor):

This letter is meant to inform you that the treatment provided by (name of therapist) to you or your dependent (named above) is undergoing review and that the present outstanding claim for that provider's services has been suspended pending the outcome of professional review. I would like to emphasize that this review is routine and, assuming that the judgment of the reviewers is that the treatment is of adequate quality and medically or psychologically necessary, the claim will be processed as usual and your treatment may continue to be reimbursable under the CHAMPUS Program.

The Office of CHAMPUS (OCHAMPUS) conducts ongoing professional reviews of mental health services at established intervals to ensure that beneficiaries are receiving quality mental health services. (Insert the following for outpatient care:) When psychotherapy sessions are rendered on an outpatient basis, professional review occurs at the 24th and 48th session. Peer review (conducted by psychologists, psychiatrists, psychiatric nursing specialists, clinical social workers, or marriage and family therapists) monitors the appropriateness of outpatient mental health services when the treatment episode reaches the 24th session. (Insert the following for inpatients:) All inpatient psychiatric services undergo peer review upon reaching the 30th inpatient day. Please note that after the 30th inpatient day, the fiscal intermediary must also notify you that CHAMPUS' Basic Program Benefits will only pay for an additional 30 days of inpatient care (unless a waiver request is submitted and approved by OCHAMPUS).

If the final review decision is other than full approval of the treatment, you will be notified of the decision, its rationale, and your right to appeal. Thank you for your cooperation in this matter. I may be contacted at: (phone number) if you have any questions.

Sincerely,

Second Level Reviewer's Name)

Please refer to COM-FI, Part Two, Chapter 1, paragraph V.B.3. for information required on controlled return letters.

SAMPLE LETTER TO BENEFICIARY REQUESTING TREATMENT REPORT (WHEN PROVIDER IS NON-PARTICIPATING)

Date
Re: Treatment of
(Beneficiary's Name)

Dear (Beneficiary or Sponsor):

A CHAMPUS claim for (in/outpatient) mental health care provided to you or your dependent (named above) by (name of therapist) covering services from (date) to (date) has been received.

The Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) requires that additional information be obtained from patients receiving psychotherapy. This information is critical to our claims review process. A request for the information was sent to your provider and, to date, we have received no response to that request. We are sending this second request directly to you so that you may remind your provider to complete the treatment report which was previously sent to him/her.

The paragraphs below outline the condition(s) which may apply. Please note the instructions and request that your therapist take the actions necessary for the processing of your claim.

___ This claim covers the ___24th ___48th ___other (___) outpatient treatment session. Further documentation is required before it can be processed. Please have your provider complete and return the attached Treatment Report. If it is not received by (date), the claim will be denied.

___ Previous peer review of this case resulted in the decision to review treatment again at the time of the ___th session or inpatient day. In order to complete the review, it is necessary to have further documentation. Please complete and return the attached Treatment Report. If it is not received by (date), the claim will be denied.

___ This claim covers the 24th outpatient treatment session or the 30th inpatient day (select one). In order to initiate peer review, an updated treatment report must be completed. Please have your provider complete and return the attached Treatment Report. If it is not received by (date) the claim will be denied and you will be responsible for paying all charges.

Please refer to COM-FI, Part Two, Chapter 1, paragraph V.B.3. for information required on controlled return letters.

SAMPLE LETTER TO BENEFICIARY REQUESTING TREATMENT REPORT (WHEN PROVIDER IS NON-PARTICIPATING)

-2-

___ This claim is for testing and/or assessment and requires further documentation before it can be processed. Please have your provider complete and return item 4 of the attached treatment report. If it is not received by (date), the claim will be denied.

___ This claim covers services or a pattern of services which require further documentation before it can be processed. Please have your provider complete and return the attached Treatment Report. If it is not received by (date), the claim will be denied.

Sincerely,
(Second Level Reviewer's Name)

Enclosures:
Treatment Report
Pre-addressed envelope

SECTION II

Dictionary of Key Terms

APPROPRIATE MEDICAL CARE:
Services performed in connection with the diagnosis or treatment of disease or injury, pregnancy, mental disorders or well-baby care which are in keeping with the generally accepted norms for medical practice in the United States.

ASSESSMENT:
A general term for evaluating a patient in order to answer specific questions. It may include psychological testing, interview procedures, report preparation, interpretative interviews, or some combination of these. Testing is a specific form of assessment and uses formal tests such as those described in Appendix 3, "Selected Standard Psychological Tests."

*CASE CONFERENCE MODEL:
*Conducting a case review at a fiscal intermediary or the Office *
*of CHAMPUS where a number of cases are presented by second level *
*reviewers at a scheduled time to a designated professional peer *
*reviewer. Cases are prepared in advance by second level re- *
*viewers. Discussion is provided, as required on a case-by-case *
*basis with the peer reviewer, who provides recommendations used *
*for benefit determinations. Cases will be presented in either *
*written or oral form as determined by the unit referring the *
*case for review.

COLLATERAL:
A term used to define a session between a provider and a significant person in the identified patient's life. It is conducted for the purposes of gathering information and/or implementing the patient's treatment goals. 'Significant others' may include spouses, parents, siblings, grandparents, guardians, or teachers. By nature, the COLLATERAL visit does not require the presence of the identified patient during the session, although this may occur.

CONFIDENTIALITY:
The degree and circumstances by which information obtained through diagnostic or therapeutic interventions between patients and providers are protected from public use for fear of misuse or misinterpretation. CHAMPUS' peer review system requires that all treatment and peer review reports prepared for FI or professional review be assigned a patient identification number. Thus, cases are identified and filed by code number, not the patient's name. All treatment reports are thoroughly sanitized thereby removing the

(last) names of patients and providers. In addition, peer reviewers' names are also removed from Peer Review Reports prior to their being forwarded to the provider.

CONJOINT THERAPY:
A collective term used to indicate a category of therapies where more than the therapist and the patient are in treatment session at the same time--i.e., one or more family members. Conjoint therapy is classified as a form of group therapy. Conjoint therapy may include, but is not necessarily limited to marital (couples) therapy and family therapy.

CORE CRITERIA
Guidelines as specified in this manual which apply to all mental health claims or cases regardless of whether they are for inpatient or outpatient services. Core criteria are utilized by fiscal intermediaries' first and second level reviewers.

CRISIS
A crisis almost always involves an abrupt and substantial change in behavior associated with a clear, precipitating situation causing impaired functioning or marked increase in personal distress.

CUSTODIAL CARE
Care rendered to a patient (a) who is mentally or physically disabled and such disablility is expected to continue and be prolonged, and (b) who requires a protected, monitored, or controlled environment whether in an institution or in the home, and (c) who requires assistance to support the essentials of daily living, and (d) who is not under active and specific medical, surgical, or psychiatric treatment which will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment.

FAMILY ASSESSMENT
Gathering information on the strengths and weaknesses of the family to understand its internal and external interactions as well as its influence on the patient's dysfunction. Information may include (but is not limited to): the hierarchical structure; communication styles; roles and alliances; decision-making capabilities; and, the ability to maintain appropriate boundaries within the family and its external environment.

MEDICALLY OR PSYCHOLOGICALLY NECESSARY
The frequency, extent, and types of medical services or supplies which represent appropriate medical care and that are generally accepted by qualified professionals to be reasonable and adequate for the diagnosis and treatment of illness, injury, pregnancy, and mental disorders or that are reasonable and adequate for well-baby care.

MENTAL DISORDER
A nervous or mental condition that involves a clinically significant behavioral or psychological syndrome or pattern that is associated with a painful symptom, such as distress, and that impairs a patient's ability to function in one or more major life activities.

MENTAL STATUS
The psychological and behavioral appearance or a person. Mental status exams may contain reference to the following: 1) attitude and general behavior; 2) attitude and behavior during interview; and 3) sensorium, mental grasp and capacity.

PARTIAL HOSPITALIZATION
A psychiatric treatment program for patients requiring the specialized treatment and supervision of a hospital environment but not on a full-time basis. Patients may: 1) go to the hospital for treatment during the day and return home at night (Day Hospital); 2) work in the community during the day and return to the hospital after working hours (Night Hospital); or, 3) live in the hospital during the weekend and resume their usual work or activity schedule outside the hospital during the week.

PEER REVIEW
The evaluation by professionals (both medical and non-medical) of the effectiveness of services ordered or performed by those in similar professions or disciplines. Thus, CHAMPUS' peer review procedures for monitoring mental health services operate with the participation of physicians, psychologists, clinical social workers, certified psychiatric nurse specialists, and marriage and Family Therapists or Pastoral Counselors.

PROSPECTIVE REVIEW
Analysis of planned interventions to determine whether they are consistent with established criteria. Prospective reviews are initiated when psychoanalysis is selected by the provider to be the treatment of choice, new or unusual services are proposed for the patient or an extension to the sixty-day limitation on inpatient care is being sought.

PSYCHOSOCIAL HISTORY
The gathering of relevant data on social, cultural, medical, and psychological conditions and events in the patient's past to foster an understanding of current problems in social functioning.

QUALITY OF CARE
The degree or grade of excellence of medical sevices. Quality of care is frequently considered in light of structure, process or output variables. Structure refers to the number, type and quality of resources used in rendering health services. CHAMPUS' education and training requirements for authorized providers are an example of structural determinants which may foster quality care. Process variables measure the degree of conformity to what, by consensus, are the most appropriate and effective procedures for the delivery of care. The core and special criteria of first and second reviewers which are used to screen exceptions to these norms of care are examples of process variables. Outcome variables seek to measure the degree to which the goals of therapeutic interventions have been attained. Outcomes may be expressed in terms of the patient's complete restoration of mental or physical functioning or the attainment of the highest level possible of adaptive functioning. Information on the progress of treatment and reasons for termination (which are solicited on treatment reports) help reviewers to gauge the effectiveness of treatment interventions.

RESIDENTIAL TREATMENT CENTER
A facility or distinct part of a facility that provides, to children and adolescents, a total, twenty-four hour, therapeutically planned group living and learning situation where distinct and individualized psychotherapeutic interventions can take place. A residential treatment center is organized and professionaly staffed to provide residential treatment of mental disorders to children and adolescents who have sufficient intellectual potential to respond to active treatment (that is, for whom it can reasonably be assumed that treatment will result in an approved ability to function outside the residential treatment center), for whom outpatient treatment is not appropriate, and for whom a protected and structured environment is medically or psychologically necessary.

RESTROSPECTIVE REVIEW
Examination of services which have already been rendered using both explicit (i.e., written) and implicit (or subjective) criteria.

SESSION
A continuous, single face-to-face contact between therapist and patient(s) or collateral.

SHOCK TREATMENT
Shock treatment is a form of psychiatric treatment in which electric current, insulin, carbon dioxide or Indoklon is administered to the patient to induce loss of consciousness or a convulsive or comatose reaction to alter favorably the course of the illness. ECT is an effective treatment in certain cases of severe depression, psychosis, catatonia, or mania. ECT is not generally used for the treatment of behavior disorders, character disorders, anxiety neurosis, or feelings of depression related to recently saddening or disappointing events in life. In addition, the use of ECT on children and adolescents is restricted to rare and exceptional occasions.

SOCIAL ASSESSMENT
A current description of the patient's coping abilities within the family, community, workplace, or others with whom interaction is expected or required. When indicated, the social assessment may include a description of cultural factors which could limit, inhibit or foster the ability of the patient to cope in a given situation.

SPECIAL CRITERIA
Guidelines which are applied to inpatient or outpatient care exclusively (see First Level Review) or which are organized according to Diagnosis, Treatment Modality, Testing and Assessment, or Treatment Setting (See Second Level Review).

TREATMENT EPISODE
A period of regular and continuous psychotherapeutic treatment. A break or interuption in the treatment pattern of greater than six (6) months for outpatient care is considered to end a treatment episode. Hospitalization exceeding sixty (60) continuous days of confinement also constitutes a break in outpatient treatment.

SECTION III

DEFINITIONS OF TREATMENT PROCEDURES

I. Individual (Psycho) Therapy

a. Activity Therapy. A form of individual therapy used with older children and adolescents that emphasizes developmental mastery of age-appropriate activities.

b. Behavior(al) Therapy. An approach to treatment based on the assumption that problems involved in mental disorders are, like all other behavior, learned. Once learned, problem behaviors continue because they have consequences which are reinforcing. Behavior therapy involves techniques designed to eliminate undesirable behaviors and replace them by more appropriate ones. The emphasis in therapy is upon behavior rather than feelings or underlying causes. Behavior therapists tend to be active in therapy and the patient often has specific exercises to carry out in situations beyond the therapy setting.

c. Client-Centered Therapy. A form of therapy based on the assumption that persons have within themselves the capacity for growth and maturation of personality. However, a variety of personal and interpersonal obstacles may prevent a person from achieving maximum potential. It is believed that by providing a therapeutic atmosphere of acceptance and encouragement of self-examination and reflection, personal growth toward self-actualization may be fostered. Therapeutic procedures emphasize the importance of the therapist as a sounding board for the patient's thoughts and feelings and avoidance of direct intervention.

d. Cognitive Therapy. A therapy based on the assumption that inappropriate behavior stems from faulty thinking. The aim of therapy is to alter attitudes, expectations and perceptions in order to change behavior in more appropriate ways.

e. Crisis Intervention. A therapy based on the assumption that when persons are in a crisis situation, a relatively intense and focused intervention can help to stabilize the patient and the situation and prevent deterioration and avoid inpatient care. Crisis intervention often requires longer and more frequent treatment sessions, but crises should be resolved in a matter of days.

f. Directive Therapy. A form of therapy in which the therapist plays an active role by giving reassurances and advice, asking questions and offering information. Directive therapists may give specific advice or urge the patient to follow certain courses of action.

g. Electic Therapy. A pragmatic approach to therapy based on the assumption that by choosing the best, most effective elements from a variety of therapies, a maximally-effective treatment package can be devised for each patient and problem.

h. Existential Therapy. An approach to therapy in which emphasis is placed on self-discovery and self-realization. The patient is encouraged to be him or herself rather than constantly adapting to the desires and expectations of other people and to look to the present rather than trying to discover causes of current problems.

i. Gestalt Therapy. A form of therapy based on the assumption that mental health problems result from disturbances in the relationship between a person and his/her environment. Gestalt, a German word, means form or figure and refers here to the figure that a person represents when seen against the environment or background. The therapy emphasizes the development of new and more creative ways of adjusting to reality.

j. Humanistic Therapy. A rather general approach to therapy which emphasizes the need for the patient and therapist to relate to each other as persons rather than as a sick person to healer. The therapy has the primary aim of promoting self-actualization, helping the person to realize his/her unique potential rather than the achievement of any particular socially-desirable goal such as success or acceptance.

k. Hypnotherapy. Treatment by means of hypnosis, often used in conjunction with another therapeutic approach such as directive, eclectic, or psychoanalytic therapy. Hypnosis is more frequently used to remove symptoms by direct suggestion that they will disappear or to bring back forgotten experiences so they can be dealt with appropriately.

l. Insight-Oriented Therapy. A form of therapy which focuses on uncovering hidden or unconscious emotional factors involved in mental health problems. The emphasis is more on feelings than on ideas, and treatment procedures are designed to work through a patient's unconscious defenses to understand problem areas more fully. It is expected that once patients have a good grasp of the underlying causes of their problems, insight will result in improvement in the problem areas. (Sometimes the term insight-oriented is used to describe psychoanalytic or psychodynamic therapies, but it could apply to other therapy approaches, as well.)

m. Non-Directive Therapy. An early name for what is now termed Client-Centered Therapy.

n. Play Therapy. Type of psychotherapies used with children, usually of preschool and early latency ages. The patient reveals his or her problems on a fantasy level with dolls, clay, and other objects. The psychotherapist utilizes this level of interaction to provide interventions and explanations about the patient's responses and behavior in language geared to the child's comprehension.

o. Psychoanalysis. Psychoanalytic treatment seeks to eliminate or diminish undesirable effects of unconscious conflicts by making the patient aware of their existance, origin, and inappropriate expression in current emotions and behavior. The patient's relationship with the therapist is of critical importance and is thought to accurately reflect the patient's problems and conflicts, expecially those growing out of early childhood problems. Psychoanalysis usually requires treatment in several sessions each week over a period of several years.

p. Psychoanalytic Therapy. A form of therapy based on psychoanalytic principles and assumptions about the importance of unconscious factors in mental health problems. However, the aims and practices of psychoanalytic therapy are generally more limited than those of psychoanalysis so that the focus is more on eliminating particular problems than on restructuring the entire personality and both frequency and length of treatment are less than in psychoanalysis. There is relatively more emphasis on conscious and environmental factors.

q. (Psycho) Dynamic Therapy. This is usually an alternative label for Psychanalytic Therapy (see above) or Insight-Oriented Therapy.

r. Rational-Emotive Therapy. A form of therapy which, like cognitive therapy, is based on the assumption that mental health problems arise out of faulty ways of thinking. The aim of therapy is to teach the patient to distinguish between his irrational beliefs about self and world and those beliefs which are rational and supportable so that the patient becomes more realistic. The techniques are often similar to those of behavior therapy and cognitive therapy.

s. Supportive Therapy. A form of therapy most often employed with persons not deemed suitable for more intensive and intellectually demanding therapies. It involves direct help, reassurance, and encouragement by the therapist in order to strengthen and improve existing behavior systems rather than develop new ones.

t. Systems Therapy. An approach to therapy which views the individual as a member of a system (i.e., family, workplace, school, neighborhood, social group). The focus is on the individual's interactions within the system and how the system maintains the pathology, rather than emphasizing the individual pathology itself.

u. Transactional Analysis. An approach to therapy which views the basic processes of personality as transactions between different levels of development within the person and which are then reflected in transactions with other persons. Every person is assumed to have adult, parent and child levels of interactions so that it is possible to study his/her transactions and see them as involving, for example, parent talking to child and vice versa. It is believed that by studying and analyzing these levels, the person may be helped to achieve a more effective level and style of functioning.

II. Family (Psycho) Therapy (general definition).

The object of family therapy is to alter the family influences that contribute to the disorder of one or more members. The family usually meets as a group with the therapist who acts as a participant observer. Interpretations of interactions and resolutions of conflicts and developing functional patterns among the members are proposed. The goal of family therapy is not only to improve individual adjustment of family members but to create a more effective way of living as a unit.

a. Behavioral Family Therapy. Therapy using basic learning techniques such as reinforcement, extinction training, desensitization, role-playing, and modeling to elicit the desired group behaviors.

b. Cognitive Restructuring Family Therapy. Therapy focusing on the family's orientations and perceptions as a whole. Its goal is to define and restructure the cognitive processes which influence the family's objectives, attitudes, and behavior (see definition I,b Individual Cognitive Therapy).

c. Communications Theory Family Therapy. An approach to therapy in which each family member is seen as a part of the communication system. The form of communication, accuracy of perception, and use of feedback by each family member is examined. Communication theory includes analyzing the factors influencing effective transmission of information. These include examination of the origins and distortions of information, conflicting messages, pooling and organization among members for group communication, and types of communication feedback.

d. Network Therapy. A type of family therapy which includes extended family members, friends, neighbors, and work and social associates in the family therapy process. Such a network has the advantage of a common experiential background and involvement in each others' lives as well as a great potential for quickly developing creative solutions to problems. The goals of network intervention include increasing knowledge and insight into predicaments for which the network may be responsible, modifying socially-shared pathologies, and avoiding labeling only one or a few members of the family unit as emotionally disturbed.

e. Psychoanalytic Family Therapy. Therapy based on modified principles of psychoanalysis. Treatment focuses on family interaction as contributing to the management of the family as a group. Emphasis is placed on the emotional and cognitive factors in the family and the relationship of the individuals to the group.

f. (Psycho) Dynamic Family Therapy. Therapy involved with the interpretation of behavior and mental states in terms of mental forces or processes of the family members.

g. Structural Family Therapy. A method of family therapy which views family pathology as residing within subsystems of the family unit. Treatment alternates between seeing the family as a unit and seeing key subsystems of that unit.

h. Systems Theory Family Therapy. An approach to therapy which views the family as a unit, a larger and more comprehensive system than an individual, but also comprised of various small subsystems. The focus is on the interactions within the system, how the individual fits into the system or subsystem, and how the system maintains the pathology, rather than emphasizing the individual pathology itself.

III. Group (Psycho) Therapy (general definition).

A form of treatment in which two or more patients and the psychotherapist participate to resolve difficulties and effect therapeutic changes. Group size usually ranges from four-to-ten participants and lasts one-and-a-half hours once each week (with the exception of couples therapy). Interactions among group members are the focus of attention.

a. Activity Group Therapy. A form of group therapy used with older children and adolescents that emphasizes developmental mastery of age-appropriate activities.

b. Behavioral Group Therapy. Therapy concerned with the elimination of symptoms and the acquisition of successful coping mechanisms through modification of faulty behavior patterns.

c. Directive Group Therapy. A type of treatment designed to help group members adjust to their environment. It includes such activities as didactic and educational group work, group counseling and guidance, and therapuetic recreation. The therapist is quite active and at the center of group activities.

d. Eclectic Group Therapy. Therapy having a diverse array of treatment procedures which can be employed to effect changes in the variety of problems found among the group members. The therapist guides activities according to his/her best judgment about what is likely to be effective at the time.

e. Existential Group Therapy. Therapy which focuses on self-discovery and self-realization which in turn helps individuals of the group feel less estranged from one another, react spontaneously to life situations, and develop a sense of responsibility for their own actions. The therapist and group members try to: 1) know one another by communicating and entering into one another's world; 2) discover each person's basic personality needs and values; and, 3) help free each person from fears and conflicts in realizing individual potential.

f. General Systems Group Therapy. Therapy concerned with identifying the organization and interacting components of systems (i.e., the group, subgroups, or the individual in his environment). By recreating the roles, relationships, inputs, and flow of communication within the system and subsystems, the therapist attempts to assist group members in gaining understanding and control of group process.

g. Gestalt Group Therapy. Therapy concerned with changes in pathological perceptions of the individual and the collective perceptions of the group as they affect attitudes and behavior. Internal experiences are analyzed and the goal is to overcome the separation of thinking, feeling, and acting.

h. Humanistic Group Therapy. The goal is self-realization or self-actualization, i.e., a healthy and creatively functioning person. The group is employed to help each person explore feelings and develop a sense of individual worth through mutual support and trust.

i. Insight-Oriented Group Therapy. The group is used to achieve greater insights into patterns of maladjustment (see definition I,k, Individual Insight-Oriented Therapy). Group members learn to respond to hidden meaning and unexpressed feelings to bring about increased awareness and personal insight.

j. Play Group Therapy. A form of group therapy with children using play equipment in a projective manner.

k. Psychoanalytic Group Therapy. The application of such psychoanalytic concepts as transference, free association, dreams, and historical development in groups, The group recreates the original family, facilitating the resolution of problems. The members serve as co-therapists, especially through the use of the technique going around, in which each member free associates about another member.

l. Psychodrama. A form of group therapy in which a person is asked to act out meaningful situations in the presence of others (e.g., the group, the therapist, or an audience) who confront him/her on various issues. Each participant has specific functions designed to help the subject understand him or herself and to act spontaneously, which facilitates self-understanding.

m. (Psycho) Dynamic Group Therapy. An approach to therapy closely related to Insight-Oriented and Psychonalytic Therapies. Emphasis is on underlying or hidden motivations which are apparent as group members interactand become more aware of each other's personalities, needs and aims. Increased awareness brings opportunities for control and restructuring.

n. Rational-Emotive Group Therapy. Therapy based on the view that emotional difficulties are due to faulty, illogical attitudes which can be altered by controlling one's thought processes. During group therapy, attention is focused on current modes of behavior, not on delving into the past or uncovering unconscious biological urges. The group may be effective in bringing out irrationalities and self-defeating ideas and in suggesting alternative views on behavior.

o. Reality Group Therapy. An approach to therapy featuring two characteristics: 1) the therapist advocating conventional, responsible and moral behavior for the patient and 2) focus on the here and now aspects of the group process rather than historical aspects. Reality therapy has been used especially with adolescent delinquents.

p. Supportive Group Therapy. A form of therapy aimed at reinforcing existing defenses and alleviating immediate distress. The most frequently used measures are reassurance, encouragement, approval of desirable behavior, persuasion, and inspirational group therapy. The group serves as a source of mutual support and encouragement for each member as well as reflection of reality against which members can test their ideas.

q. Transactional Group Therapy. A form of therapy designed especially for groups whose multitude of transactions reveal the individual's internal states lying behind social responses. The object of the therapy is to make each participant aware of the parent, adult and child components of his attitudes, feelings, and behavior so that he/she can learn to function in a more integrated manner and to analyze and elaborate self-defeating role "games" which are seen as the source of most psychopathology.

SECTION IV

SELECTED STANDARD PSYCHOLOGICAL TESTS

Category I: Intelligence and Achievement Tests

Bayley Scales of Infant Development
Goodenough Draw a Man Test*
McCarthy Scales of Children's Abilities
Peabody Picture Vocabulary Test*
Stanford-Binet Intelligence Scale, form L-M*
Vineland Social Maturity Scale*
Wechsler Adult Intelligence Scale (WAIS)
Wechsler Intelligence Scale for Children - Revised (WISC-R)
Wechsler Preschool and Primary Scale of Intelligence (WPPSI)
Wide Range Achievement Test (WRAT)*

Category II: Projective Personality Tests

Children's Apperception Test (CAT)
Figure Drawings, Draw-A-Person, House-Tree-Person, Projective Drawings *
Holtzman Inkblot Technique
Rorschach Test
Sentence Completion Tests *
Thematic Apperception Test (TAT)

Category III: Self-Administered Tests:

California Psychological Inventory (CPI) *
Edwards Personal Preference Schedule (EPPS) *
Minnesota Multiphasic Personality Inventory (MMPI) *
16 Personality Factor Questionnaire (Cattell) *
Strong Vocational Interest Blank *

Category IV: Neuropsychological and Screening Tests:

Bender Visual-Motor Gestalt Test *
Halstead-Reitan Neurolpsychological Battery for Children (9-14)
Halstead-Reitan Neuropsychological Battery for Adults (15 and over)
Luria-Nebraska Neuropsychological Battery
Reitan-Indiana Neuropsychological Battery for Children (5-8)
Illinois Test of Psycholinguistic Abilities (ITPA)
Memory for Designs Test (Graham-Kendall) *
Beery-Buktenica Developmental Test of Visual-Motor Integration (VMI) *

* These tests normally require a half-hour or less of professional time.

SECTION V

CAUSES OF INPATIENT AND OUTPATIENT TREATMENT

Data obtained from CHAMPUS' Users Guide For Psychiatric Reports For Care Provided Under the CHAMPUS Program in Fiscal Year 1980 (CHAMPUS' Information Systems Division, Aurora, Colorado, July 1982) show that the five most frequently cited mental health diagnoses for 1980 were:

1. Neuroses (DSM-III Anxiety and Dysthymic Disorders);
2. Schizophrenia (DSM-III Schizophrenic Disorders);
3. Transient Situational Disturbance (DSM-III Adjustment Disorder);
4. Active psychoses (DSM-III Psychotic Disorders Not Elseswhere Classified; and,
5. Behavior Disorders of Children (DSM-III Anxiety Disorders of Children and Adolescence and Personality Disorders in Children and Adolescence).

Since the aforementioned diagnoses will be found frequently on treatment reports, second level reviewers should consult the DSM-III to learn more about the causes and symptoms of these dysfunctions.

One determinant of quality care is the appropriateness of services. This means that not only should treatment procedures conform to generally accepted norms of medical practice in the United States, but also that the delivery setting (i.e. where services are rendered) should correspond to the nature and severity of the dysfunction. Second level reviewers should recognize that the decision to treat patients on an inpatient or outpatient basis is not arbitrarily determined by the provider. As a result, brief descriptions of why patients are treated in these settings are offered below.

A. Reasons for Initial Admission or Continued Hospitalization

One or more of these reasons may be given in each case. In addition, justification in narrative form will be presented in a variety of ways.

1. Actual or potential danger to self, other, or property. This may be indicated by the patient's overt attempts to commit suicide or injure himself, others,

or cause property damage. In the absence of overt actions, such danger may be inferred by threats, poorly controlled expressions of anger, or a high degree of tension from the suppression of feelings.

2. Inability to tolerate outpatient treatment. Indicated when the patient is significantly disorganized and unable to cooperate in an outpatient treatment program manifested by failure to keep appointments or to take prescribed medications. There may also be a need to monitor a patient closely during the initial stages of drug therapy to determine the appropriate dosage.

3. Noncompletion of planned treatment relating to:

   a. Drugs. Indicated by a lack of adequate expected therapeutic response to the drug, a need for continued adjustment of dosage, continued handling of side reactions, or consideration of alternative drugs.

   b. Integrated therapy (individual, group or rehabilitative). Indicated by a lack of adequate expected therapeutic response and/or inadequate involvement of the patient as an active participant in the treatment program.

   c. Reintegration into the community. Persistent illness resulting in the failure of the patient to re-establish various meaningful relationships and activities that existed prior to hospitalization and that are essential for a return to adequate functioning.

   d. Other. May be incompletion of diagnostic study or specific treatment programs such as ECT which should be clearly related to the treatment program.

4. Psychiatric or other medication complications. This might relate to specific complications that arise from drugs, confusion induced by ECT, intense anxiety from insights uncovered in psychotherapy, or any medical problem that necessitates continued hospitalization in its own right (e.g. intercurrent illness or convulsion from withdrawal or barbituates).

5. Serious intensification of illness. Indicated by an increase in the intensity of symptoms or the development of additional symptoms leading to severe dysfunction requiring hospitalization. For example, a depressed patient may develop suicidal rumination.

6. Change of diagnosis or failure of treatment necessitating change of treatment plan. Evidenced when a patient displays symptomatology during the course of hospitalization that was unknown to the physician at the time of admission. For example, a patient originally diagnosed as a Transient Situational Disturbance may show continued symptomatology indicative of another specific psychiatric disorder. A changed treatment plan may be necessary when a depressed patient fails to respond to antidepressant medications and it is determined that ECT is needed, or when a patient fails to respond to supportive psychotherapy and a more intensive insight-oriented psychotherapeutic approach is indicated.

7. An inability of the patient to care for himself or function in daily routine. The psychotic patient's mental functioning may be sufficiently impaired to grossly interfere with the capacity to meet the ordinary demands of life. The impairment may result from serious distortions in the capacity to recognize reality. Symptoms may include hallucinations and delusions or profound alterations in mood.

8. Continuation of maladaptive behavior. Although the specific symptoms of the psychiatric disorder have lessened, critical problems may continue to impair the patient's ability to adapt to the normal demands of life. For example, an adolescent might be less anxious but may continue to be highly disturbed and disruptive with his family situation; an executive might continue to display indications of poor control and judgment; or an individual might feel overwhelmed and unable to cope with familial demand.

9. Cited treatment plans have not been fully completed. Although improvement has occurred, it is not of the degree deemed appropriate and necessary for the particular patient. This can be intensified by a comparison of the goals specified in the treatment plan with the patient's progress. The goal may be to reduce violent, disruptive behavior. The frequency of such

episodes may have been reduced from what they were upon admission but are not yet at a level considered acceptable to allow discharge to outpatient status.

B. Symptoms or Reasons for Mental Health Treatment on an Outpatient Basis

Listed below are twelve common reasons that justify outpatient psychotherapy:

1. Intense anxiety. Anxiety attacks with apprehension, tachycardia, sweating, or faintness. Chronic anxious states may also be characterized by tension, sleep disturbance, difficulty in carrying out usual activities, or excessive use of alchohol or drugs.

2. Anxiety or depression accompanied by somatic complaints. Palpitations, flushing, subjective sense of impending disaster, sense of faintness, tightness of chest, nausea and perspiration, fearfulness, apprehension, or severe insomnia are examples of physiological changes due to severe anxiety.

3. Depression or other neurotic-like or related symptoms, with impaired familial, occupational, or educational functioning. Apathy, loss of interest, decreased self-esteem guilt, self-destructive ideation, depression, depersonalization, fatigue, conversion symptoms, dissociative state, phobia, obsessive or compulsive rituals which hinder the individual's activities of daily living.

4. Real or present danger to self, others or property. These may include destructive gestures, threats, or thoughts about harming self, others or property.

5. Substance abuse (alcohol or drugs) and planned detoxifiation or follow-up to inpatient detoxification. Excessive use or abuse of chemicals should be treated in conjunction with a detoxification program if dependence or addiction is presumed on the basis of history or if in response to the withdrawal or decrease in alcohol intake, the patient develops symptoms such as anxiety, irritability, difficulty sleeping, agitation, loss of appetite, or nausea.

6. Hypomania or mania manifested by elation, irritability, talkativeness, flight of ideas and/or accelerated speech or motor activity. These symptoms may also be accompanied by poor judgment, excessive spending, change in usual patterns of behavior.

7. Impairment of orientation, memory, intellectual functioning, judgment, or affective response. The individual may be unaware of time, place, or person, confused, fearful, or forgetful. These symptoms may occur only when the person is fatigued or under pressure.

8. Impaired thinking and affect, perception or disordered behavior. Bizarre, delusional, illogical, loose, blocked markedly unrealistic, or flighty thoughts may be prevalent. Persons with impaired affect may appear ambivalent, experience inappropriate moods, depression, gloom, or apathy. Characteristics of disordered perception include hallucinations, illusion or depersonalization. Withdrawal, regression, bizarre or inappropriate motor retardation or agitation might signal disordered behavior.

9. Impaired familial, educational or occupational functioning. Inability to accomplish age appropriate role expectations such as parenting or attending school.

10. History of hospital treatment for mental illness within the past three months. Outpatient treatment is appropriate as a follow-up to inpatient hospitalization.

11. Mental and Emotional Problems of Children (under 18 years). Significant developmental delay secondary to emotional illness, antisocial behavior that is self-destructive or dangerous to others, or an inadequate living situation that requires support. All might warant outpatient therapy rather than institutionalization.

12. Personality Disorders. Inflexible and maladaptive personality traits which cause either significant impairment in social or occupational functioning or subjective distress.

SECTION VI

Psychotropic medications compose one of the largest classes of and most often prescribed drug groups in the United States. For this reason alone, assurance of prescribing practices in keeping with current U.S. usage standards has major health implications.

The psychopharmologic criteria contained in this appendix are explicitly intended for screening use, and do not constitute prescribing guidelines or definitive standards. This appendix is designed to assist a knowledgeable non-physician (i.e. second level reviewer) to select from a large number of cases a relatively small number for which peer review is appropriate.

I. Alcohol

a. Breath tests
.0% = Normal
Under 0.05% = Not legally under influence
0.15% to 0.25% = Intoxicated *
0.25% and up = Marked intoxication and stupor (at 0.40% coma starts and at slightly higher levels death ensues).

b. Blood

Negative = normal

II. Barbiturates

Negative = normal
8 mg/100 ml (long acting) = coma
4 mg/100 ml (medium acting) = coma
2 to 2.5mg/100 ml (short acting) =coma

III. Red Blood Count

4 - 6 million cu/mm. = normal

IV. White Blood Count

4 - 11 thousand cu/mm. = normal

*Note: Many state laws say 0.10% is legal evidence of under the influence.

V. White Blood Count Differential

Neutrophiles	54% -63%
Eosinophiles	1% -3%
Basophiles	0% -1%
Lymphocytes	25% - 33%
Monocytes	0% -9%

VI. Calcium

9.0 - 11.4 mg/100ml or 4.5 - 5.7 mEq/L

VII. Ceruloplasmin

20 - 35 mg/100ml = normal
Decreased in Wilson's disease

VIII. Dilantin (Diphenylhydantoin)

None = normal
15 - 20 mcg/ml = Therapeutic range
30 - 40 mcg/ml = Mild toxicity
Over 40 mcg/ml = Serious toxicity

IX. Folic Acid (Usually for alcoholism when it is depressed)

7- 16 ng/ml (nanogram/ml) in some or
4 - 20 ng/ml in others

X. Glucose

80 - 120 mg/100 ml serum = normal

XI. Lithium

For patients on maintenance medication, laboratory studies other than serum lithium determinations, such as measurement of blood urea nitrogen, electrolytes, or throid function, are recommended when indicated clinically, but not on a routine basis. Pregnancy and breast feeding are considered to be relative contradictions to use of lithium because of difficulties in plasma level stabilization during the last trimester, and possibility of a higher incidence of fetal cardiovascular abnormalities, and the appearance of lithium in human milk. Concomitant use of lithium and an antipsychotic medication for mania or lithium and an antidepressant for depression are appropriate where satisfactory control cannot be achieved with either drug alone. Lithium is so rarely indiated for children less than 12 years of age that they are included under relative contraindications for review purposes.

None = normal range
0.15 - 1.5 mEq/L = Therapeutic levels
Over 2.0 mEq/Liter = Severe toxic reactions may occur

XII. Magnesium (serum)

1.5 - 2.5 mcg/100ml = normal

XIII. Potassium (serum)

3.5 - 5.0 mEq/L =normal

XIV. Sodium (serum)

136 - 145 mEq/L = normal

XV. Chloride (serum)

100 - 106 mEq/L = normal

XVI. Enzymes (serum)

a. Amylase 80 - 180 Somoqyi units/100 ml. = normal
b. SGOT 5 - 40 units (Karmen)/ml = normal

XVII. Lipids (serum)

Cholesterol 150 - 250 mg/100 ml = normal

XVIII. Non-protein Nitrogenous Substances

a. Bilirubin (serum) 0.3 - 1.1 mg/100 ml - normal
b. Blood Urea Nitrogen (Blood) 10 - 20 mg/100 ml - normal
c. Creatinine (serum) 0.7 - 1.5 mg/100ml =normal
d. Non-protein Nitrogen (NPN) (serum) 15 -35mg/100ml =normal
e. Uric Acid (serum) 3 -6 mg/100ml =normal

XIX. Protein Bound Iodine (PBI) (serum)

3.5 8 mcg 1/100ml = normal

XX. Spinal Fluid (normal)

a. Cells 0 - 8 cell/cu mm

b. Chlorides 118 - 133 mEq/L for adults 120 - 128 mEq/L for children

c. Protein
15 - 45 mg/100 ml for adults
15 - 45 mg/100 ml for children

d. Serology Negative

e. Sugar
45 - 75 mg/100 ml for adults
35 - 75 mg/100 ml for children

XXI. Cortisol (Levels of serum cortisol are measured for suppression following oral administration of dexamethasone. In an endogenous depression the patient will manifest positive results indicating that Cortisol has not been suppressed. As a confirmatory test for endogenous depression the Dexamethasone Suppression Test or DST is 90% effective and only 50% effective when used as a screening test in diagnosing.)

Positive - Greater than 5 mcg/deciliter

XXII. Tricyclic Antidepressant Plasma Concentrations:

Documentation of physical examination and findings within six months for outpatients as an alternative to examination immediately prior to initiating treatment is recommended for tricyclic antidepressants.

Because of their wide variability in size and metabolic rate, the ususal dosage range for children less that 12 years of age is greater than for adults. Body weight may provide some guidance to pediatric dosage, with 5 mg. of imipramine/kg (or the equivalent dosage of the other tricyclic antidepressants) being appropriate in many cases. However, metabolic differences may require doses greater or less than this. In some instances full adult dosage of tricyclic antidepressants may be necessary for children.

Drug	Therapeutic Range (Maximal Effect)
Amitriptyline	80-120 ng/ml
Imipramine	225-240 ng/ml
Nortriptyline	50-150 ng/ml
Desipramine	80-175 ng/ml
Doxipin	110-250 ng/ml
Protriptyline	70-250 ng.ml

SECTION VII

TO BE UPDATED

Model Psychopharmacologic Screening Criteria

prepared by

The American Psychiatric Association

SECTION VIII

REFERENCE TEXTBOOKS

Second Level Reviewers may want to consult the following recommended references to obtain additional information on the several classes of mental health providers or general information on mental health theory and practice.

American Nurses' Association

1. American Nurses' Association, Division on Psychiatric and Mental Health Nursing Practice; Standards of Psychiatric and Mental Health Nursing Practice; Kansas City, MO;: American Nurses' Association, 1982.
2. American Nurses' Association, Division on Psychiatric and Mental Health Nursing Practice; Statement on Psychiatric and Mental Health Nursing Practice; Kansas City, MO;: American Nurses' Association, 1976.
3. American Nurses' Association, Congress for Nursing Practice; Nursing: A Social Policy Statement; Kansas City, Mo;: American Nurses' Association, 1980.
4. Haber, J., Leach, A. M., Schudy, S. M., Sideleau, B. F.; Comprehensive Psychiatric Nursing, Second Edition; New York: McGraw-Hill Book Company, 1982.

(References from the American Psychiatric Association, the American Psychological Association and the National Association of Social Workers may be added in the future)

APPENDIX
B

CHAMPUS POLICY MANUAL

VOLUME TWO

APPENDIX B

CHAMPUS AUTHORIZED RESIDENTIAL TREATMENT CENTERS

FACILITY	OCHAMPUS RATE
Higdon Hill School and Group Home 7009 5th Avenue, South P.O. Box 2896 Birmingham, AL 35212 Facility No. 01-00234 EIN: 63-0516927 (A)	**67.00**
Arizona Children's Home Association 2700 South 8th Avenue Tucson, AZ 85713 Facility No. 03-00005 EIN: 86-0096772 (A)	**82.00**
Camelback Hospital-Wendy Paine O'Brien Center-RTC 1300 North 77th St. Scottsdale, AZ 85257 Facility No. 03-00205 EIN: 86-0170221 (B)	**229.00**
Devereux Center in Arizona 6436 E. Sweetwater Scottsdale, AZ 85254 Facility No. 03-00199 EIN: 23-1390618 (E)	**113.00**
Desert Hills (Jay McCaffrey) 5245 N. Camino De Oeste Tucson, AZ 85745 Facility No. 03-00148 EIN: 86-0276013 (A)	**199.00**

FACILITY	OCHAMPUS RATE
Phoenix Camelback Hospital 5055 N. 34th Street Phoenix, AZ 85018 Facility No. 03-00202 EIN: 86-0170221 (A)	248.00
San Pablo Residential Treatment Center 4001 North 30th Street P.O. Box 10526 Phoenix, AZ 85064 Facility No. 03-00046 EIN: 86-0182627 (A)	83.00
Westbridge RTC (Century Health Care of AZ) 367 North 21st Avenue Phoenix, AZ 85009 Facility No. 03-00209 EIN: 73-1195659 (A)	246.00
Elizabeth Mitchell Children's Center 6601 West 12th Little Rock, AR 72204 Facility No. 02-00038 EIN: 71-0415350 (A)	155.00
Devereux Schools in California Box 1079 Santa Barbara, CA 93102 Facility No. 04-00028 EIN: 23-1390618 (B)	72.00
Boys & Girls Aid Society of San Diego, LTD Box 278 Spring Valley, CA 92077 Facility No. 04-00353 EIN: 95-16439/9 (A)	179.00

FACILITY	OCHAMPUS RATE
CPC Vista Del Mar 801 Seneca Street Ventura, CA 93001 Facility No. 04-09162 EIN: 95-1907817 (A)	116.00
Edgewood Children's Home 1801 Vicente Street San Francisco, CA 94116 Facility No. 04-00247 EIN: 94-1186168 (A)	123.00
Southwood Psycniatric RTC (Hillcrest) 4307 Third Avenue San Diego, CA 92103 Facility No. 04-01613 EIN: 95-2749700 (A)	248.00
Southwood Psycniatric RTC (Southbay) 3 North Second Avenue Chula Vista, CA 92010 Facility No. 04-09122 EIN: 95-2749700 (B)	248.00
Sunny Hills Children's Services 300 Sunny Hills Drive San Anselmo, CA 94960 Facility No. 04-00099 EIN: 94-1156301 (A)	113.00
The Re-Ed West Ctr for Children, Inc. Box 568 or Box 875 Carmichael, CA 95608 Facility No. 04-00356 EIN: 94-2519001 (A)	94.00

FACILITY	OCHAMPUS RATE
Fred Finch Youth Center 3800 Coolidge Avenue Oakland, CA 94602 Facility No. 04-00122 EIN: 94-0474080 (A)	135.00
Rio Vista Residential Center 11490 South Rio Vista Reedley, CA 93654 Facility No. 04-01669 EIN: 94-1412648 (A)	194.00
San Diego Center for Children 3002 Armstrong Street P.O. Box 11024 San Diego, CA 92111 Facility No. 04-00256 EIN: 95-1661089 (A)	190.00
Serendipity Schools 6441 Matheney Way Citrus Heights, CA 95610 Facility No. 04-00482 EIN: 94-2291751 (A)	147.00
Forest Heights Lodge Box 789 Evergreen, CO 80438 Facility No. 05-00037 EIN: 84-0439961 (A)	83.00
The Mesa School 1353 South 8th Street Colorado Springs, CO 80906 Facility No. 05-00183 EIN: 84-0602716 (A)	71.00

FACILITY	OCHAMPUS RATE
Terry Children's Psychiatric Center 10 Central Avenue New Castle, DE 19720 Facility No. 07-00007 EIN: 51-6000279 (A)	129.00
Montanari RTC and Clinical Schools 291 East Second Street Box 1360 Hialeah, FL 33011-1360 Facility No. 09-00006 EIN: 59-0819359 (A)	60.00
Anneewakee, Inc Star Route Box 73 Carrabelle, FL [redacted] Facility No. 09-00594 EIN: 58-0873694 (B)	103.00
Camelot Care Center P.O. Box 1101 Lutz, FL 33549 Facility No. 09-00599 EIN: 36-2935664 (C)	101.00
Gulf Coast Hospital (RTC) 1015 Mar Walt Drive FT. Walton Beach, FL 32548 Facility No. 09-09163 EIN: 56-1341134 (A)	*
La Amistad/La Casa Vida 201 Alpine Drive Maitland, FL 32789 Facility No. 09-00194 EIN: 59-1300982 (A)	121.00

*under development

FACILITY	OCHAMPUS RATE
Northside Community Mental Health Center, Inc., Adolescent Treatment Program 13301 North 30th Street Tampa, FL 33612 Facility No. 09-00598 EIN: 59-1641327 (A)	195.00
Daniel Memorial 3725 Belfort Road Jacksonville, FL 32216 Facility No. 09-09154 EIN: 59-0668479 (A)	147.00
Devereux Schools in Georgia 1980 Stanley Road, NW Kennesaw, GA 30144 Facility No. 10-00219 EIN: 23-1390618 (C)	137.00
Anneewakee Treatment Center 4771 Anneewakee Road Douglasville, GA 30135 Facility No. 10-00021 EIN: 58-0873694 (A)	103.00
Laurel Heights Hospital 934 Briarcliff Road, N.E. Atlanta, GA 30306 Facility No. 10-00303 EIN: 58-0437760 (A)	184.00
Salvation Army Facilities for Children 845 22nd Avenue Honolulu, HI 96816 Facility No. 51-00020 EIN: 99-0073542 (A)	97.00

FACILITY	OCHAMPUS RATE
Kahi Mohala 91-2301 Fort Weaver Road Ewa Beach, HI 96706 Facility No. 51-00082 EIN: 74-2123972 (A)	248.00
Intermountain Hospital of Boise - RTC 303 N. Allumbaugh Street Boise, ID 83704 Facility No. 11-00048 EIN: 82-0358058 (A)	210.00
Camelot Care Center 1502 Northwest Highway Palatine, IL 60067 Facility No. 12-00265 EIN: 36-2935664 (A)	101.00
Allendale School P.O. Box 277 Lake Villa, IL 60046 Facility No. 12-00268 EIN: 36-2177140 (A)	92.00
Evansville Psychiatric Children's Center 3300 E. Morgan Avenue Evansville, IN 47715 Facility No. 13-00029 EIN: 35-6000158 (A)	152.00
St. Francis Boys Home Box 1348 Salina, KS 67401 Facility No. 15-00037 EIN: 48-0543809 (A)	50.00

FACILITY	OCHAMPUS RATE
Children's Treatment Services Bureau of Hlth Serv River Region Hospital Anchorage, KY 40223 Facility No. 16-00061 EIN: 61-0600439 (A)	248.00
DePaul Hospital-RTC 1040 Calhoun Street New Orleans, LA 70118 Facility No. 17-00157 EIN: 62-1113736 (A)	245.00
River Oaks Hospital (RTC) 1525 River Oaks Road, West New Orleans, LA 70123 Facility No. 17-00158 EIN: 72-0687735 (A)	248.00
Good Shepherd Center 4100 Maple Avenue Baltimore, MD 21227 Facility No. 19-00072 EIN: 52-0608774 (A)	62.00
Hawthorne Center 18471 Haggerty Road Northville, MI 48167 Facility No. 21-00072 EIN: 38-6000134 (A)	242.00
Gerard Schools of Minnesota Box 715 Austin, MN 55912 Facility No. 22-00038 EIN: 41-0952856 (A)	130.00

FACILITY	OCHAMPUS RATE
Boys Town of Missouri, Inc. P.O. Box 189 St. James, MO 65559 Facility No. 24-00251 EIN: 43-0681471 (A)	*
Crittenton Center 10918 Elm Avenue Kansas City, MO 64134 Facility No. 24-00129 EIN: 44-0545808 (A)	107.00
HSA Heartland Hospital 1500 W. Ashland Nevada, MO 64772 Facility No. 24-00238 EIN: 43-1328523 (A)	56.00
Yellowstone Boys & Girls Ranch Route #1, Box 212 Billings, MT 59102 Facility No. 25-00043 EIN: 81-0262019 (A)	81.00
Uta Halee Girls Village 10625 Calhoun Road Box 12034 Florence Station Omaha, NE 68112 Facility No. 26-00045 EIN: 47-0384338 (A)	75.00
The New Mexico Children's Psychiatric Center 1001 Yale Avenue NE Albuquerque, NM 87131 Facility No. 29-00091 EIN: 85-6000642 (A)	193.00

*under development

FACILITY	OCHAMPUS RATE
Camelot - St. Francis Boy's Home PO Box 550 50 Riverside Drive Lake Placid, NY 12946 Facility No. 30-00479 EIN: 23-7004958 (B)	71.00
Convalescent Hospital for Children 2075 Scottsville Road Rochester, NY 14623 Facility No. 30-00137 EIN: 16-0743972 (A)	84.00
HSA Cumberland Hospital 3425 Melrose Lane PO Box 42308 Fayetteville, NC 28304 Facility No. 31-00243 EIN: 56-1107292 (A)	248.00
Bellefaire 22001 Fairmount Boulevard Cleveland, OH 44118 Facility No. 33-00033 EIN: 34-0714630 (A)	99.00
Hannah Neil Center for Children 301 Obetz Road Columbus, OH 43207 Facility No. 33-00282 EIN: 38-1359593 (A)	63.00
Christopher Youth Center 2741 East 7th Street Tulsa, OK 74104 Facility No. 34-00110 EIN: 73-1097218 (A)	113.00

FACILITY	OCHAMPUS RATE
Dillon Family and Youth Svcs, Inc. Shadow Mountain Institute 6262 South Sheridan Road Tulsa, OK 74133 Facility No. 34-00055 EIN: 73-0803421 (A)	148.00
High Pointe/Shadow Mountain Institute 6501 N.E. 50th Street Oklahoma City, OK 73141 Facility No. 34-00114 EIN: 73-0803421 (B)	148.00
Devereux Center in Pennsylvania 19 South Waterloo Road Devon, PA 19333 Facility No. 36-00011 EIN: 23-1390618 (A)	66.00
Camelot Care Center Route 3 Kingston, TN 37763 Facility No. 39-00150 EIN: 36-2935664 (B)	101.00
Goodlark Residential Treatment Facility 222 Church Street Dickson, TN 37055 Facility No. 39-00162 EIN: 62-0788376 (A)	*
St. Joseph Hospital-Children and Youth Unit-RTC 220 Overton Memphis, TN 38105 Facility No. 39-00155 EIN: 62-0488040 (A)	212.00

*under development

FACILITY	OCHAMPUS RATE
Brown Schools Box 4008 East 32nd Street Austin, TX 78765 Facility No. 40-00016 EIN: 74-2208682 (A)	195.00
DePelchin Faith Home (Bayou Place Residential Treatment Center) 100 Sandman Houston, TX 77007 Facility No. 40-00686 EIN: 74-1157363 (A)	94.00
Devereux Center in Texas Box 2666 Victoria, TX 77901 Facility No. 40-00021 EIN: 23-1390618 (D)	110.00
El Paso Center for Children, Inc. 3700 Altura Blvd. El Paso, TX 79930 Facility No. 40-00394 EIN: 74-1695944 (A)	66.00
San Antonio Children's Center 2939 West Woodlawn Avenue San Antonio, TX 78228 Facility No. 40-00690 EIN: 74-1153067 (A)	214.00
Meridell Achievement Center Box 9383 Austin, TX 78766 Facility No. 00015 EIN 74-1655289 (A)	$193.00

FACILITY	OCHAMPUS RATE
Woods Psychiatric Institute Box 5749 Abilene, TX 79605 Facility No. 40-00271 EIN: 75-1334763 (A)	248.00
Hillside School, Inc. 683 East 4th North Logan, UT 84321 Facility No. 41-00019 EIN: 87-0283899 (A)	39.00
Residential Treatment Center Primary Childrens Medical Center 363 12th Avenue Salt Lake, UT 84104 Facility No. 41-00046 EIN: 94-2854057 (A)	87.00
Brattleboro Retreat (104 LINDEN Program) 75 Linden Street Brattleboro, VT 05301 Facility No. 52-00031 EIN: 03-0107360 (A)	177.00
Charter Colonial Institute 17579 Warwick Boulevard Newport News, VA 23603 Facility No. 42-00394 EIN: 58-1492652 (A)	248.00
DeJarnette Center P.O. Box 2309 Staunton, VA 24401 Facility No. 42-00061 EIN: 54-6001727 (A)	248.00

FACILITY	OCHAMPUS RATE
Eastern Virginia Center for Children and Youth AKA Community Men Hlth Ctr & Psych Inst. 721 Fairfax Avenue P.O. Box 1980 Norfolk, VA 23501 Facility No. 42-00387 EIN: 54-6055378 (A)	248.00
Graydon Manor 301 Children's Center Road Leesburg, VA 22075 Facility No. 42-00038 EIN: 54-0739116 (A)	208.00
Portsmouth Psychiatric Center 301 Fort Lane Portsmouth, VA 23704 Facility No. 42-00384 EIN: 54-1326795 (A)	248.00
Psychiatric Institute of Richmond 3001 Fifth Avenue Richmond, VA 23222 Facility No. 42-00345 EIN: 52-0962719 (A)	244.00
Tidewater Psychiatric Institute 1701 Will-O-Wisp Drive Virginia Beach, VA 23454 Facility No. 42-00284 EIN: 52-0907278 (A)	248.00
Seattle Children's Home 2142 10th Avenue West Seattle, WA 98119 Facility No. 43-00317 EIN: 91-0565572 (A)	248.00
Willowglen Academy 1111 Reed Street Plymouth, WI 53037 Facility No. 45-00152 EIN: 39-1174376 (A)	63.00

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